the MODERN HOSPITAL

VOLUME 54 · FEBRUARY 1940 · NUMBER 2

Garland installation in the kitchen of the Episcopal Hospital at Philadelphia, Pa.

32% Saving in Gas Proves Garland's Promise of Economy!

Perhaps you have noticed that Garland advertising—and Garland representatives—invariably stress the economies that may be expected from Garland gas-fired heavy-duty cooking equipment. These statements are not just "sales promises." They are backed up by the actual experience of Garland users, in all parts of the country, in all types of large-scale cooking service—from large metropolitan hotels, hospitals, and restaurants to the smallest village tea-room.

The experience of the Episcopal Hospital at Philadelphia is a good example of the kind of savings made possible through the use of Garland equipment. The management reports a fuel saving of 32% since the installation of Garland equipment. In addition, Garland equipment makes for a more efficient kitchen, improved service, and more palatable food.

We should be glad of an opportunity to tell you how you, too, may enjoy these worthwhile Garland advantages. Write, wire, or phone.

GAS IS THE IDEAL FUEL and at its Best with GARLAND Heavy-Duty Equipment

GARLAND

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CONTENTS

For February 1940

Vol. 54, No. 2, February 1940

Just in Passing—

A 24 PAGE portfolio covering many aspects of present day hospital planning will greet your eyes when you open the March issue of this magazine. Leading hospital architects in all parts of the United States have contributed to make this portfolio outstanding.

Among the subjects to be covered are planning small hospitals, wards, nursing units and power plants. The remainder of the portfolio will be devoted to a discussion of preferred types of windows, floors and floor coverings, acoustical materials, air conditioning, lighting, bathing facilities, vacuum and pressure outlets and explosionproofing.

MUCH has been written on laundry layout and organization but few articles are as good as the one by Dr. A. K. Haywood and his associates, which we shall present next month.

BELOW is a "routing sheet" for your copy of The MODERN HOSPITAL. To use it, just put a large rubber band around the copy to hold it open at this page. If you would prefer to attach a routing sheet to the outside of the magazine, we shall gladly provide copies on request. Only when all of the department heads in your institution read the magazine will you get all possible benefits from your subscription.

READ AND PASS ON

	See page	Date
Administrator		
Purch. Agent	.....	.....
Supt. of Nurses	.....	.....
Surg. Supervisor	.....	.....
Dietitian	.....	.....
Housekeeper	.....	.....
Pharmacist	.....	.....
Engineer	.....	.....
Laundry Manager	.....	.....
Radiologist	.....	.....
Pathologist	.....	.....
Chief of Staff	.....	.....
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Return to .....

The Modern Hospital

Published monthly and copyrighted, 1940, by The Modern Hospital Publishing Company, Inc., 919 N. Michigan, Chicago, and 101 Park Avenue, New York City. Otho F. Ball, president; Raymond P. Sloan, vice president; Stanley R. Clague, secretary; J. G. Jarrett, treasurer. Yearly subscription, U. S. A. and Canada, $3; foreign, $4. Single copies: current, 35c; back, 50c to $1. Entered as second-class matter, Oct. 1, 1918, at the post office at Chicago, Ill., under the act of March 3, 1879. Printed in U. S. A.

Solely for Salads

• One of the spots of interest at Orange Memorial Hospital, Orange, N. J., these days is a salad icebox. Behind it lies a story. Before it lies a useful career in saving time and in improving the quality of salads.

It seems that when the hospital kitchens were remodeled more than 10 years ago, an irregular space was left behind one of the built-in iceboxes and closed off with a door. For years, this was used to store odds and ends, though, being warm and having no ventilation, things in it did not keep well. Salads and cold dishes had to be carried the length of the main kitchen and placed in boxes holding fruit and vegetables. Facilities were limited and the accommodations were far from adequate; besides a great deal of labor was involved in making many trips back and forth between the points of preparation and storing.

"So," says Stanley Howe, the superintendent, "we finally persuaded our board to spend approximately $600 to insulate this area and to install a refrigerator door and cooling coils from our refrigerating plant. Simple racks were made by the maintenance department, using angle iron and flat bars as supports.

"The bars bend at the ends so that they can be lifted off for cleaning, thus reducing the number of crevices in which moisture or dirt can accumulate. The box has a capacity of about 125 salads, in addition to a considerable quantity of fruit juices, cream and broths. The closet is conveniently located and adjoins the point at which the food trucks receive their last check before leaving the kitchen and at which cold dishes are put on.

"It is thus possible to prepare salads far ahead of a meal hour because they keep crisp and fresh for a long time in this box, whereas, before, much of this work had to be done at the last moment in order to deliver the salads in the best condition."

The salad icebox at the Orange Memorial Hospital, Orange, N. J., is an example of what can be done with a little ingenuity, at slight expense. A cubbyhole formerly used to store odds and ends is now an important part of the food service department and has resulted in a saving of both time and energy.

Happy Birthday

• Margaret E. Kennedy, superintendent of the Sanitarium of Paris at Paris, Tex., has been introduced by your Roving Reporter on several different occasions. She was telling us recently about their Christmas celebration—but that's a story that must wait for another time.

What interests us right now, and we think it will interest you, too, is that each employe of the sanitarium receives a check for $1 as a greeting on his birthday.

This might not be possible in the larger hospitals perhaps, but it is excellent for building good will among the employes of a small institution. The Sanitarium of Paris, when the Roving Reporter visited it last, numbered about 72 beds.

Patients' Questionnaire

• That is a simple but effective questionnaire that the Southside Community Hospital at Farmville, Va., is distributing to patients to check on the service rendered. It is just a slip of paper with a brief message from the superintendent at the top and with five questions listed below with space for answers. At the very bottom is a line for the patient's name and the date.

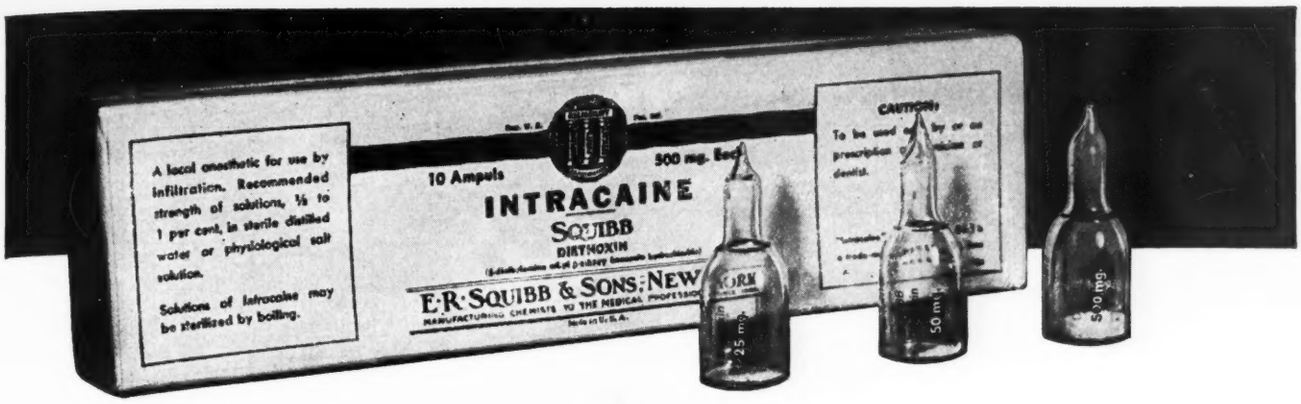
"It is the desire of this institution," it reads, "to render every service possible for the comfort and well-being of the patients.

"You, as a patient, can help greatly if you will answer the questions below and give your frank opinion of the service you have received. Information given here will be held in strict confidence."

Now come the questions.

1. Was the hospital care you received satisfactory? (If not please state why and give names.)
2. Was the food satisfactory?
3. Was there much noise?
4. Have you any criticism of the hospital?
5. Have you any suggestions for the improvement of the hospital?

The hospital hasn't been distributing these long enough to draw any conclusions but, unless your Roving Reporter is much mistaken, that simple piece of paper will prove to be a most important document.



Infiltration Anesthesia with *Intracaine* in 0.5% solution

***"gave immediate and effective anesthesia without subjective discomfort"*[1]**

INTRACAINE (Squibb Diethoxin) is a new anesthetic agent intended especially for use in producing regional anesthesia by infiltration and nerve block, and for spinal anesthesia. It has a higher anesthetic index than procaine hydrochloride and, in equivalent concentrations, induces an appreciably longer anesthesia. There has been a significant absence of local reactions such as erythema, burning or after-pain.

INTRACAINE IN LOW SPINAL ANESTHESIA

In a clinical study of 100 cases, Sappenfield and Rovenstine[3] conclude — "Intracaine possesses some advantages as a mild anesthetic agent, useful in low dosage and low concentrations, for surgical procedures that involve no structures above the lower abdomen." With a 25-milligram dose, 45 minutes of satisfactory anesthesia for perineal operations may be anticipated. Blood pressure, pulse and respiratory changes resemble those with procaine hydrochloride.

RAPID IN ACTION

McIntyre and Sievers,[2] reporting an extensive series of minor surgical operations, state that Intracaine is completely free from irritating effects and so rapid in action that practically no pain is felt at the moment of injection. No immediate or delayed toxic reactions were observed.

Rovenstine and Cullen,[1] in using Intracaine for infiltration anesthesia, remark: "The diffusibility of the drug in tissue was marked, that is, a wider radius of the anesthetic zone followed subcutaneous linear injections."

HOW SUPPLIED

Intracaine — Squibb Diethoxin (Beta-Diethylaminoethyl Para-Ethoxy Benzoate Hydrochloride)—is supplied as follows:

Crystals: 500-mg. ampul; 25- and 50-mg. ampuls in boxes of 10 (for spinal anesthesia); ½- and 3-oz. bottles (for prescription purposes).

Tablets: 25 mg. each, vials of 20 and bottles of 100.

---

[1] Rovenstine, E. A., and Cullen, Stuart C.: *Anesthesia & Analgesia* 18:86 (March-April) 1939.

[2] McIntyre, A. R., and Sievers, R. F.: Article presented at meeting Federation of American Societies for Experimental Biology, Baltimore, March 31-April 2, 1938.

[3] Sappenfield, R. S., and Rovenstine, E. A.: Article presented at the Forum of Anesthetists, St. Louis, May 15-19, 1939.

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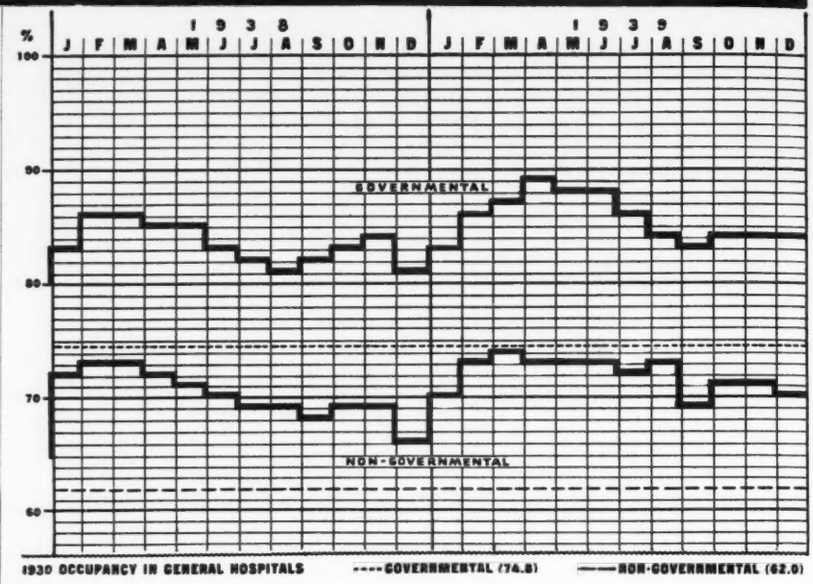
HOSPITAL OCCUPANCY BAROMETER

Type and Place	Census Data on Reporting Hospitals: Hosp.[1]	Beds[2]	1939: Dec.	1939: Nov.	1938: Dec.	1938: Nov.
Government:						
New York City	17	10,579	92	92	94	96
New Jersey	4	2,236	86*	86*	80	90
Washington, D. C.	1	1,220	70*	70*	70*	70*
N. and S. Carolina	18	2,221	70	70	65	71
New Orleans	2	2,397	106*	106*	97	97
San Francisco	3	2,255	96	96	88	92
St. Paul	1	850	67	67	72	69
Chicago	2	3,500	89	89	83	85
Total[4]	48	25,258	84*	85*	81*	84*
Nongovernment						
New York City[3]	68	15,194	77*	77*	69	73
New Jersey	59	9,938	70*	70*	64	68
Washington, D. C.	9	1,818	72*	72*	72*	72*
N. & S. Carolina	105	7,009	63	65	59	64
New Orleans	7	1,198	67*	74*	64*	70
San Francisco	16	3,178	71	75	69	71
St. Paul	9	1,150	69*	69	71	70
Chicago	16	2,832	59	65	58	65
Cleveland	7	1,044	77	78	71	74
Total[4]	296	42,361	70*	72*	66*	70*

[1]Excluding hospitals for tuberculous and mental patients and Institutional hospitals. Census data are for most recent month. [2]Excluding bassinets, usually. [3]General hospitals only. [4]Occupancy totals are unweighted averages. *Preliminary report. Complete occupancy figures for January 1933 to November 1939 are given on page 1010 of The Eighteenth Hospital Yearbook.



December Occupancy Breaks Records; Prices More Stable

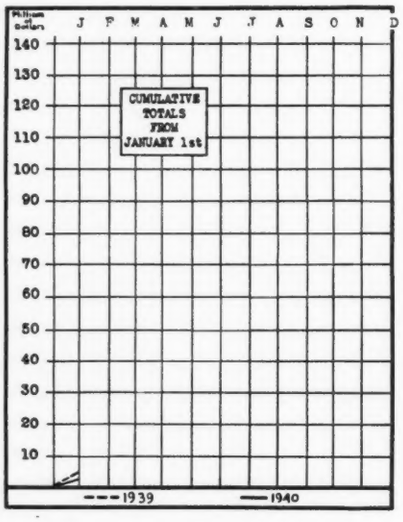
Occupancy in the nongovernmental general hospitals dropped during December in accordance with the usual Christmas lull. The preliminary figures showed an occupancy of 70 per cent for December, which was well ahead of the figures given for December 1938 and for any other December for which we have records. More complete reports may bring this figure down somewhat but it probably still will remain a high point.

The figures for governmental general hospitals also were high in December, the occupancy reported being 84 per cent. This is the highest occupancy reported since December 1934, when these hospitals were still greatly overcrowded from the effects of the depression.

Hospital construction projects reported up to January 15 numbered 32, of which 30 gave costs aggregating $2,469,919. This was considerably below the total reported for previous Januarys but was, undoubtedly, caused by the fact that the reports covered only one-half of a month.

There were 12 new hospitals included in this month's projects, of which 11 gave costs of $880,772. Seventeen projects were for additions to existing buildings and 16 of these sent in cost figures which came to a total of $1,323,900. Three nurses' home projects were expected to cost $365,247.

HOSPITAL CONSTRUCTION



The general wholesale price index of the *New York Journal of Commerce* showed little change in the period from December 16 to January 13. It was 81.8 on both dates, in the meantime having advanced to 82.4 and then dropped back. Grain prices declined slightly after their rapid rise in December, going during the period under review from 76.1 to 74.0. On November 18, however, the index for grain prices had been at 65.5. General food prices advanced during the period but then returned to approximately the same level at 66.8. Textile prices did the same, ending the period at 79.3 after an advance to 82.0. Fuel advanced one point and building materials remained unchanged. The price of drugs and fine chemicals, as reflected by the *Oil, Paint and Drug Reporter* index, advanced from 194.8 to 196.7 (based on prices as of August 1, 1914).

Average weekly earnings in American industry in November were only 0.2 per cent below those in 1929, a steady rise since last July. This brings the total to $28.49, while the average worker's real income, that is, his money earnings adjusted for changes in the cost of living, was 16.6 per cent higher than in 1929, according to a survey by the National Industrial Conference Board.

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Out of 438 Pequot sheets tested in the past 6 years, *every one* has exceeded U. S. Government specifications. We challenge any other sheet manufacturer to produce such a record. *No* other sheet has ever shown such evidence of *uniform* high quality, steadily maintained.

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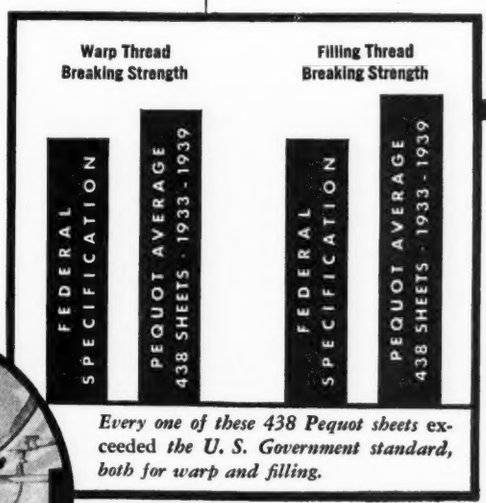
5. The sheets have double tape selvages so constructed as to give a high degree of strength and protection to the edges of the sheet.
6. The amount of sizing or filling is minimum - just sufficient to create a pleasing finished appearance.

From the results of our analyses, we find that Pequot Sheets conform to a high standard of quality, such as to warrant complete consumer satisfaction.

Very truly yours

UNITED STATES TESTING COMPANY, Inc.

E. J. Donohoe
Manager



Every one of these 438 Pequot sheets exceeded *the U. S. Government standard, both for warp and filling.*

PEQUOT SHEETS AND PILLOW CASES

Every **PEQUOT SHEET** and **PILLOW CASE** made from Selected Cotton, and

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for its purchases of heavy muslins. . . . NO LOADING OR FILLING — the slight trace of necessary finishing materials guaranteed to average less than 1%.

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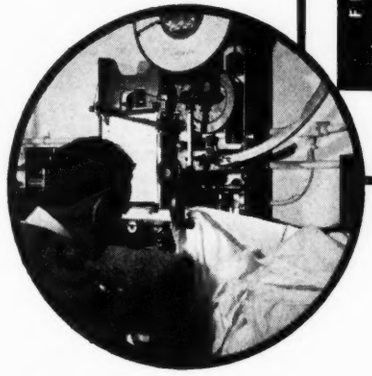
1. SUPER-SERVICE heavy muslin construction.
2. RETAINS WHITENESS and fine surface appearance after repeated washings.
3. DOUBLE TAPE SELVAGES* strengthen and protect edges of each sheet.
4. LESS THAN AVERAGE SHRINKAGE shown by impartial tests.
5. PATENTED SIZE INDEX TABS enable quick selection of correct size sheet right from linen shelf.

There is only ONE grade of Pequot super-service muslin—sold only under the Pequot shield trade-mark.

*Reg. U. S. Pat. Off.



PEQUOT SHEETS AND PILLOW CASES

SMALL HOSPITAL QUESTIONS

This department is conducted with the cooperation of Gladys R. Brandt, R.N., Cass County Hospital, Logansport, Ind.; A. F. Branton, M.D., Willmar Hospital, Willmar, Minn.; Oliver K. Fike, Grace Hospital, Richmond, Va.; Mrs. Jewell W. Thrasher, R.N., Frasier Ellis Hospital, Dothan, Ala., and others

Cleaning Infected Rooms

Question: We occasionally get a communicable disease patient who comes in to be treated for some other condition. Of course we do not ordinarily accept them. When we do, what procedure should be followed after the patient's discharge? Do we have to wash everything in the room? Does the mattress have to be sterilized? What other steps should be taken to prevent any spread of the infection?—J. S. C., Ala.

Answer: After the patient is discharged, a nurse, wearing gown, mask and cap, should go into the room and raise the windows and shades. All paper and waste should be burned and all linen should be placed in an isolation laundry bag. Enamel and glassware are soaked in cresylic acid solution; dishes, silver and glassware are washed in a special dishwasher. The houseman should take the mattress, pillows, blankets and rubber sheets out into the sun and air for a day or two. If the weather is unfavorable, these articles should be kept in the infected room until it is possible to air them. After they have been aired, the blankets, linen and rubber sheets should be laundered and the mattress, damp brushed.

The door of the room should be closed while the room is aired for ten or twelve hours. At the same time, cabinets and dresser compartments should be opened for airing.

Furniture should be washed with soap and water and then polished; walls should be washed or painted; window shades, damp dusted; windows and woodwork, washed or painted; hand signal and light fixtures, washed, and the floor, scrubbed, waxed and polished. The room should remain unoccupied as long as possible.

When the disease has been acutely communicable, the window shades are raised, the linens are removed and the room is left untouched for twelve hours before the procedures mentioned are observed.

Occasionally, we have a surgical patient who is also suffering from a communicable disease. In that instance, the patient's room is prepared for the operation; one surgical nurse is assigned for duty inside the room and one (who remains clean), outside the room. A stretcher carries all sterile supplies, which are passed in by the nurse outside the door. Contaminated linens are left in the room; the floor nurse places linens in the laundry isolation bag and cleans the room after the operation. Gloves and instruments are placed in basins of germicidal solution on the stretcher and are returned to the surgery for boiling.

Providing Surgical Supplies

Question: We have a new man on our medical staff who thinks we are running a hick hospital because the doctors are expected to provide their own instruments and rubber gloves. What do other hospitals of our size (45 beds) do?—A. P., Mass.

Answer: Our operating room charge includes all routine supplies and instruments. We do not purchase special instruments or supplies that are used by one surgeon only. Hours of grief can be avoided and the nurses' time saved if the hospital owns and is responsible for all equipment.

Information to the Press

Question: Our weekly newspaper likes to have information about all patients admitted and discharged and notes about their convalescence. (1) Is it proper to give out such information? (2) If so, should the telephone operator or the administrator do it? (3) Will our doctors be offended if we have to say from time to time that some of their patients died?—I. R. T., Minn.

Answer: (1) Yes. (2) The telephone operator should not give out information. It must come from the superintendent who understands the patient's condition and who obtains the doctor's consent. (3) There should be no offense taken by doctors for notice of deaths because these notices cannot be withheld from the public. The hospital and newspaper should strive for mutual understanding and this can be obtained only by giving the newspaper legitimate information.

Medical Records

Question: We are having difficulty in getting medical records that meet the standards of the American College of Surgeons. We don't have any interns to write them and I don't know how to get our doctors to write good, complete records.—V. C., Mich.

Answer: This question has never been solved. A few suggestions that may prove helpful are as follows:

1. The administrator can keep the problem uppermost in the minds of the doctors by constant propaganda.
2. If you have a close personal friend on the staff, persuade him to help you by setting a good example and by mentioning in staff meetings how nice it would be to work in an accredited hospital.
3. If there is a young man on the staff, have him keep his records up to date and in good shape. It may stimulate the older men.

Nursing Aids

Question: What about this business of nursing aids or attendants? Can they be used successfully in the small hospital? How can we train them or where can we obtain them already trained? What danger is there that they will set themselves up as nurses and thus be a menace to the community? How much should we pay them and what benefit will they be to the nursing staff?—C. R. S., Calif.

Answer: Nursing aids are being used successfully in many small hospitals, as well as in large institutions. Many hospitals train their own aids. For the small hospital this is probably the most feasible procedure at the present time, although courses in this type of work are now being offered in certain sections of the country. There is always a possible danger of the attendants' classing themselves as nurses in the community.

Salaries of aids are of necessity lower than those offered nurses but are in keeping with the financial status of wage earners in the community. Aids can be of great benefit by allowing the nurse more time for actual bedside duties. The status of attendants must be clearly defined and they must be supervised by registered nurses.

LOOKING FORWARD

Penalizing the Progressive

THE Supreme Court of Colorado recently held that when a charitable hospital carried liability insurance a judgment could be entered against the institution without impairing the hospital's position under the trust funds doctrine. This doctrine holds that the funds of a charitable institution cannot be diverted from the original purpose for which they were intended. The judgment would be limited to the amount of the insurance.

"We do not," the court stated, "transgress the public policy that requires immunity from tort liability of associations with trust funds dedicated to charity, but we cannot agree that this policy goes so far as to include nonliability where a charitable institution has contractually, and perhaps for the benefit of third parties, insured against its negligence. In fact, it is more reasonable to say that it is a wise precaution for such associations, in connection with their relation to those whom they serve, to protect themselves with insurance against injury resulting from their negligent acts. The procurement of such safeguard should be encouraged."

Apparently the court was dissatisfied with the results of the trust funds theory and doubted whether it was basically sound, but was unwilling as yet to discard the theory entirely. The compromise adopted seems even less tenable and introduces a vicious element into the law. If this continues to be the law in Colorado, it means that the public will not know the extent of its protection, since it will have no way of knowing whether a hospital carries insurance. Of course, the public has protection under the new ruling in some cases whereas formerly there was no redress.

The decision is unfortunate, also, from the hospital point of view. Although the court expresses the pious hope that all hospitals will carry insurance, the actual effect of the decision is to penalize the institutions that carry it. Since the plaintiff will, in effect, be suing the insurance company instead of the hospital, judgments against the insured institutions will tend to increase in number and size. This will force a rise in premiums and may make the cost of carrying this type of insurance prohibitive in the future. One administrator who has studied the matter estimates that premiums will increase sixfold at once and perhaps even more later.

Fortunately, this decision stands alone as yet, but hospital associations in other states should be alert to the danger inherent in such a ruling.

Roosevelt on Small Hospitals

IN AN interview on December 23, President Roosevelt said that he was considering a plan whereby the federal government would build small hospitals in states and localities that are too poor to provide such health facilities for themselves. Details of the plan are vague but apparently the President has in mind building about 50 hospitals of approximately 100 beds, costing about $150,000 each. They would be directed by local interests but title would be retained by the federal government.

This proposal, if it is made seriously, presents several curious aspects. First, a 100 bed hospital may seem to the President to be a small institution suitable for rural areas that are too poor to provide themselves with hospital facilities. To the hospital field, however, a 100 bed structure is a substantial institution, since more than 66 per cent of all hospitals in the United States are of much smaller capacity. Doubtless, there are communities in which a new 100 bed hospital would serve to improve the medical care of the people. But there are few, if any, areas able to support a 100 bed hospital that are at present without some kind of hospital service, however, inadequate.

Might it not be better to improve these existing facilities or at least the better ones among them, rather than to make it impossible for them to operate? If the President had suggested the construction of 10, 20 or 30 bed hospitals, his proposal would have been more in line with the thinking of careful students.

A second consideration concerns the cost. No doubt institutions can be built for $1500 per bed. However, they would have to be admittedly incomplete in facilities and services. While granting that the country needs more hospitals in certain areas, it does not need

more low grade institutions. It is doubtful if hospitals of high quality can be provided at $1500 per bed. The President suggested frame structures but this would be a dangerous step backward. Fire is serious anywhere but doubly so in an institution housing helpless patients.

A third even more disturbing aspect of the President's proposal is the federal ownership of these hospitals, either permanently or for an indefinite period. This is a far different proposal from that of the Wagner Bill, which endeavors to help local communities to help themselves. America's voluntary hospitals have suffered because of the extensive construction of veterans' hospitals and the opening of these facilities for care of disabilities that did not result from injuries received in service. This proposal goes far beyond the veterans' program. Unquestionably, federal aid is needed in some of the poorer areas. But must the price for federal aid be complete federal control and competition with local hospitals? Such a price seems excessive and unnecessary.

A fourth consideration concerns the maintenance of these institutions. Nothing is said about maintenance in the President's interview. It is obvious that areas that are too poor to construct needed hospitals will find it difficult to maintain them without aid. This would imply that the federal government, once embarked on such a program, would be unable to let go. Such aid would be unevenly extended; areas that have done little to help themselves would be given assistance, while others with perhaps only slightly higher income would receive nothing.

Finally, the President stated that the U. S. Public Health Service and "a committee of doctors" would pass on the plans and determine the ability and willingness of local communities to operate and to maintain the institutions. This is the most hopeful note that was struck in the interview, assuming, of course, that the committee of doctors would be composed of physicians with broad experience and sound judgment in hospital administration. Several officers of the U. S. Public Health Service are giving special attention to the rural hospital problem and they would bring a note of greater reality to the proposal. Certainly, the most careful study should be given to the matter of need.

The effect of the President's proposal upon the fate of the Wagner Bill is not yet entirely clear. Apparently the President is withdrawing his own personal support from the bill. When coupled with the economy drive, this may ring the death knell for the national health bill. The bill, of course, needs considerable amendment before it will meet the desires of the hospital field.

In fact, it seems probable that both the President's proposal for the building of "small" hospitals and the Wagner Bill will come to nothing, except insofar as a program of rural hospitalization, where needed, will be undertaken under the direction of the U. S. Public Health Service. Such a program will probably not contemplate any "small" hospitals of 100 beds.

Three Golden Minutes

THE subscriber can read the entire contents of The Modern Hospital in four hours. Or he can read each of the articles that appeal to him most in approximately three minutes, as clocked by one reader. It is the editors' goal to make each three minutes of professional reading, or the entire four hours, the most profitable and stimulating experience of the hospital month.

To make a professional publication like this into a sort of *Reader's Digest* composed entirely of original, written-to-order material is a tough assignment, and don't you forget it! But it is the assignment we have given ourselves and it is winning us the gratitude of readers. One subscriber recently wrote:

"These days I simply can't spare the time to dig into some of my professional magazines in search of the occasional gold nuggets I know to be hidden there. But I can read the average article in your magazine in three minutes flat. By leading me into pay dirt, you are conserving my time for everyday administrative problems. And in those three minute articles I often find the best way out of these very problems. Thanks for this saving of my time and the hospital's money."

Who Should Administer?

FOR many years an influential group of public health officials has maintained that the field of public health could be clearly defined. In their view, public health includes both activities that promote health through broad action affecting the mass of people and preventive measures that are necessary to protect the public from epidemics. Thus, the protection of water and milk supplies, the control of communicable diseases and the sanitary inspection of buildings are obviously included.

The difficulties in applying any such definition have grown apace. Maternal and child care primarily affects individuals and not masses of people. The control of the degenerative diseases, *i.e.* heart disease, cancer, diabetes and similar conditions, is increasingly being considered as a public health problem, yet these conditions must be discovered and treated in individuals, not in groups.

As the definition of public health has grown fuzzy and unsatisfactory, another important development has taken place. The provision of medical care to the indigent and to others who may be considered wards of the state has developed from a small segment of the activities of welfare departments into a very large function indeed. This is due partly to the tremendous expansion in the number of persons depend-

ent upon government aid and partly to the growth in the quality and scope of medical services.

These two important influences have doubtless been instrumental in causing some of the most prominent public health officials to jettison completely the older boundaries of their science. Dr. Edward S. Godfrey spoke for this group in his recent presidential address to the American Public Health Association:

"The one safeguard that will ensure continuance of a dynamic public health movement, with the improvement of public health as its primary object, is to place the administration of expanded governmental medical services under departments of health: national, state, city and county. Health authorities should have increasing opportunity to acquire experience in the delivery of medical care as rapidly as possible."

Although this may not be the right direction in which to move, it is certain that we must do something to correct the present overlapping, duplication and division of authority. In a recent report, the American Public Welfare Association cites a bad example:

"In one state, three different departments operate hospitals, while a fourth and fifth are responsible for payment to voluntary hospitals for the care of special categories of disease; and two additional authorities in each county, acting independently of any state authority, have the function of administering payment to voluntary hospitals for general care of the poor. The director of the state welfare department in this state was concerned over the duplication of governmental machinery for medical care and the difficulties arising from overlapping or poorly defined fields of responsibility."

Dr. S. S. Goldwater has proposed that the municipal department of hospitals in New York City be expanded to become a department of medical care to assume all medical service functions except those belonging to the health department under the classic definition of preventive medicine. Such a plan would undoubtedly work well there and in other metropolitan areas where it could be directed by medically trained persons with extensive administrative experience. As a possible alternative, Doctor Goldwater has more recently suggested the union of New York City's health and hospital departments, a plan that would permit hospitals freely to develop extramural activities that are increasingly regarded as a necessary and logical extension of hospital service to the indigent, although such activities often involve factors of prevention as well as of cure.

The volume of work to be done in a city like New York is so great that the metropolis calls for treatment as a special case. For smaller communities and for all except the large states, however, there is something to be said for an expansion of the functions of the city or state health department to include all of the medical work now carried on by departments of welfare, labor, education and other governmental divisions. Such a step would probably ensure professional guidance and a proper appreciation of the crucial importance of quality.

If they assume the administration of hospitals, however, health officers should clearly realize that such work requires technics that they do not ordinarily possess. They either should prepare themselves by proper training for hospital administration or should expect to employ persons for this work who have had training and experience in the clinical phases of medical care programs.

Teaching in the Hospital

IMPORTANT developments are taking place in medical education. A committee of younger faculty members at Yale University has recently been charged with the responsibility of re-evaluating the entire undergraduate curriculum for the medical school. In the field of graduate education, the report of the Commission on Graduate Medical Education, which is to be released sometime this spring, is being awaited with widespread interest.

Whatever changes may occur in undergraduate and graduate medical education, the hospital is almost sure to play a growing part in this activity. It is important, therefore, that hospitals give thought to their educational service to interns, to residents and to their medical staffs. Some also will participate actively in postgraduate training for general practitioners and for specialists and in undergraduate teaching for medical students.

The intern committee of the hospital should not be merely a committee for selecting interns. It should maintain an effective interest in the whole educational process during the entire year. It should make sure that there is effective teaching in the wards and clinics; that the conferences, seminars and meetings of the staff are truly educational, and that journal clubs are active and alert.

Undoubtedly, hospitals and medical schools are going to be drawn more closely together in the months and years to come. This will present certain problems of relationship, of course, but it will be a healthful stimulus for the character of service in hospitals.

The recent action of the Association of American Medical Colleges in voting to approve hospitals for internship and residency training should be considered in the light of these trends. The association has invited the hospital field to participate in the approval program, a welcome recognition of the fact that those who provide these educational opportunities have an important stake in their accreditation. Hospitals will do well to cooperate fully with the association, as well as with the other important national bodies that are interested in this field. Such cooperative effort will, in the final analysis, bring improved care for patients.

War Declared! Gloom

ROBERT M. PORTER

THE office staff and a group of technicians of the City Hospital, Akron, Ohio, decided to have a departmental picnic. There was some question as to the manner in which this affair should be carried out. Two persons around the offices had been getting mail from Corps Area Headquarters concerning their reserve officers' commission. This suggested something of a combat nature. Therefore, it was decided to stage a "War on Gloom" and to carry this theme throughout the evening's festivities.

The general theme of the campaign is indicated by accompanying bulletins, which are representative of others that were issued each day for a week before "der Tag."

Bulletin No. 1 was issued declaring war, permission having, of course, been received from the administrator, W. L. Howard, who was to serve as the commander-in-chief with the title of "Great White Father." The command was selected ad lib and plans of mobilization were developed. Daily bulletins were issued in an attempt to arouse sufficient interest in this great combat.

Camp Mingo, an isolated spot in our metropolitan park district, was chosen as Theater of Operations. It was decided that all should appear in field uniform and everyone was informed from headquarters that it was not going to be any "powder-puff" review.

The entire staff participated in this picnic. It was divided into squads, each representing a carload of people, and the party set out from the hospital in a convoy. Before entraining and while awaiting the arrival of the command car of the convoy, the officer of the day presented each person with a paper overseas cap and a wooden gun and put the squads through their paces on the rear lawn of the hospital. In a few minutes' time everyone knew the "Manual of Arms" and how to do a Squads Right, but not right by squads.

The convoy got under way about 5 p.m. and enlisted the help of a traffic officer to take it through part of the city, a procedure that was enjoyed by all. Upon arrival at Camp Mingo all troops were ordered to attention; further instruction was given them by the adjutant so that they might not fall down while passing in review before the Great White Father and selected members of the board of trustees. They were marched down to the other end of a large open field preceded by the band, composed of eight untalented musicians, who performed on various musical instruments, all of which were obtained from Woolworth's.

Prior to the review, all members were told how to do the goose step (in an exaggerated manner) and it may be left to the imagination what happened when these people passed the reviewing stand and did an "Eyes Right." No shins were shattered but some of them were badly bruised.

SPECIAL BULLETIN

September 14, 1939

WAR DECLARED

THE "GREAT WHITE FATHER," GENERALISSIMO HOWARD, HAS OFFICIALLY DECLARED WAR ON GLOOM, MELANCHOLY, DESPONDENCY AND THE MONOTONOUS BOREDOM OF WORKING FOR SUCH SLAVE DRIVERS AS PORTER, BURR, MOORE, SAYLOR AND MILLER. AS A RESULT, HE HAS ANNOUNCED, IN AN OFFICIAL DISPATCH JUST RELEASED, THAT ON THE 20TH DAY OF SEPTEMBER 1939, THE FORCES OF MIRTH, LAUGHTER, GAIETY AND HILARIOUS REFUGE WILL ENGAGE THE AFOREMENTIONED ENEMY ON THE FIELD OF BATTLE AT CAMP MINGO, METROPOLITAN PARK, AND ENDEAVOR TO ANNIHILATE SAID FOE.

Every able bodied man and woman between the ages of 16 and 60 is expected to enlist at once at the nearest recruiting station. To expedite matters, however, Major General Porter, in charge of enlistments, will have a box conveniently placed inside the dispatching office to receive voluntary enlistments.

Porter anticipates a 100 per cent enlistment and feels that "There will be no need for a draft because the loyalty behind the 'Great White Father' is tremendous, and the hatred and antagonism built up against the enemy are enough to bring up the morale to a war pitch."

Brigadier General Moore, of the Intelligence Battalion (Sees all-Knows all) has been quoted as saying, "My troops will be in force 100 per cent." Lieutenant Colonels Saylor and Miller report that spirit among their forces is at a fever pitch.

Colonel Burr, with his fiery red hair and steely glint, said, "You Know Me Chief."

So you of the First C.H.A. Regiment, show your true colors today and enlist, and show the G.W.F. that we are behind him like true patriots and loyal subjects.

Is Routed

Assistant Administrator
City Hospital, Akron, Ohio

Following this, one of the department heads gave a discourse on the use of infantry weapons, namely, the hand grenade. The company was divided into platoons. Each platoon demonstrated the use of a hand grenade. The weapons in this case were boiled, partially boiled and raw eggs.

Second on the program, carried out in a similar manner, was a discourse on the firing of a straight projectile, which was followed by a baseball throwing contest.

The next maneuver was the headliner of the day, the "big push." Instead of taking place at dawn, it took place at dusk. The forces were equally divided and given ample quantities of flour and sheets of toilet tissue (of not too great tensile strength) with which the combatants manufactured missiles of an explosive nature.

After a given period of time for manufacture of the weapons the order was given to "Charge" and many a combatant came out of the conflict with a halo around his head. It is still debatable as to who won the battle since mutiny broke out in the ranks and some of the best officers were fired upon very heavily.

Following this, came the regular military procedure of rehabilitating the casualties. Badly wounded victims were carried from the field of battle on stretchers by the litter bearing squad and were rushed to the battalion aid station where they were administered hot liquid (milk) in nursing bottles with petite nipples. What a contest this proved to be! Fortunately all survived and those who did not cooperate with first-aid treatment were sent to the guard house.

The sick and injured were examined by the x-ray department as well, and, because of the lack of x-ray equipment, it was found necessary to use bubble gum to detect any fractures of the mandible. A fair sized segment was placed on each side of the jaw and again the victims were asked to cooperate with the medical profession in an attempt to learn the extent of their injuries; those who refused were also sent to the guard house.

Throughout the activities, interest was stimulated by our clowning military police in the person of the hospital pathologist, who made many arrests and attempts to arrest and reported many cases of sabotage and mutiny.

As the shades of night fell upon the Theater of Operations a wail went up from the ranks that every army traveled on its stomach. Mess was in order. A meal of baked beans, wiener sandwiches, potato salad, coleslaw, potato chips, doughnuts, coffee and coca-cola was in order and served in true army style. After mess the military police presented their candidates for court martial, who were expediently tried before that body. Some of the charges were unjust but, nevertheless, interesting.

To relieve the minds and relax the tension of a day so filled with horror, a lone voice rang out with the strains of "K-K-K-Katie" and this was the start of numerous war ballads, which occupied the attention of the combatants for the ensuing hour. Minds now cleared, the horrors of war forgotten, a "Professor Quiz" program was in order and many questions pertinent to the operation of the hospital were propounded by the officer of the day.

Taps was sounded and the troops returned from the front and took up their original positions at the hospital, where they will hold forth until the call to the colors is again sounded.

The field uniforms of all officers and enlisted personnel showed marked originality.

FINAL BULLETIN

September 21, 1939

ARMISTICE SIGNED

ENEMY ANNIHILATED

GENERALISSIMO PLEASED

"WE HAVE MET THE ENEMY AND THEY ARE OURS," SAID THE GREAT WHITE FATHER THIS MORNING. THE WAR IS OVER AND ONCE AGAIN EVERYTHING IS PEACEFUL AND SERENE. AS FAR AS WE CAN TELL THERE WAS ONLY ONE CASUALTY, THAT BEING SGT. SPARHAWK, WHO INJURED HER NECK DURING HER ANTICS WITH CAPTAIN LINK. WE HOPE IT IS NOTHING SERIOUS. OUTSIDE OF THAT WE BELIEVE THE CAMPAIGN WAS A SUCCESS.

We want to take this opportunity to thank all those who had a part in it in any way. The band, for their fine rendition; the boys who served the food in such an excellent manner; Mr. Retzler who had the paraphernalia made, and everybody who entered into the spirit of things so wholeheartedly. And we want to save our best appreciation for those who couldn't go and had to stay on duty. Mrs. Waltershied, Miss Ethel Morey, Miss McClellan and Miss Huskey, who stayed here and took care of things without a murmur or complaint. It was swell of them and we hope they weren't too busy and that next time they all can go.

Well, it's all over now (thank goodness) and we hope everybody had a good time. We also hope we didn't slight anybody or step on anybody's toes. If we did, we are sorry, we didn't mean to, and it was all in fun anyway.

The Finance Department wants us to announce that if you had a good time, and it was worth a quarter, please pay it to Miss Powell or Miss Jessie Morey, because there was some expense connected with the festivities and although the hospital stood some of it, it didn't cover it all.

Thanks again. You are all swell soldiers and we'll see you all again sometime.

'Bye now.

Gratefully yours,
THE GENERAL STAFF

Public Apology:

Your war correspondent wishes at this time to make an apology for his journalistic efforts. We didn't pretend to be a literary genius and we do believe we could have done better had we had more time. At least that's an excuse. Anyway please forgive our butchering of the King's English. It was all in fun.

Nursing the Maternity Patient

CLARA M. KONRAD, R.N.

A DISCERNING survey of the rules and regulations that govern the nursing activities of the delivery suite will disclose whether or not the standards of that suite are designed to care for the obstetric patient adequately and to provide teaching opportunities for the student.

It is not difficult to impress the importance of these standards upon the nursing personnel. Most nurses realize that the management of this suite must always be effected under rigid aseptic procedures. Along with this knowledge go a vigilance and an alertness that are the very essence of the department.

It is generally agreed that, unless emphasis is placed upon the principles involved, intelligent and effective nursing care will not be performed. The old method of nursing is passing. We are now far more interested in whether or not the nurse understands why she is carrying out a certain nursing procedure than we are in emphasizing details of technic to the point where she may know exactly how to carry out a procedure but, when confronted with an inquiry, may find that she does not know the underlying reason for it.

Our objective, therefore, is to teach our nurses why these standards must be observed, why rules and regulations are rigidly followed and also what the outcome would be were she to forget or overlook even the most insignificant item.

Perhaps the best way to present our standards of nursing care is to follow the course of labor and delivery of a patient from the time she is admitted to the delivery suite until she is transferred to the postpartum ward or rooms and to explain why these standards have been adopted and what they accomplish.

At the Margaret Hague Maternity Hospital, Jersey City, N. J., we have divided our delivery suite into five distinct departments: labor, delivery, postpartum, operating room and central sterilizing room. The septic division, located in a separate and distinct part of the hospital, has its own delivery suite.

The first of a group of three articles on standards of nursing service in the delivery suite. This one covers the general procedures followed when the patient is first admitted to the hospital. The two succeeding articles will deal with labor room, delivery room and postpartum nursing, in that order

Upon admission of a patient, her blood is typed, blood pressure is taken, a urinalysis is made and, if this is her first hospital contact, a Wassermann test is made. If she is a new nonclinic patient the examing doctor makes a complete physical examination, including external pelvimetry.

The nurse then shaves the vulva and perineum. Care is taken not to cut or scratch the skin because, although few microorganisms can invade the unbroken skin, cuts, abrasions and even tiny pinpricks allow bacteria to enter the tissues. Because of the close proximity to the nipples the axillae are shaved at this time.

The patient is then given a slab spray bath, tub baths being contraindicated because of the danger of carrying infectious material from the bath water into the birth canal.

The method of identifying the mother with her infant is as follows: Before the mother leaves the admitting room a bead bracelet is securely fastened around her left wrist, giving her first and last name. When she is in the labor room a necklace for her baby is prepared which also states the patient's first and last names.

When the mother is delivered and before the cord is cut, the infant's necklace and mother's bracelet are compared; only after this final comparison is the doctor permitted to apply the necklace. We use the term "boy child" and "girl child" in the identification of the infant's sex, but this information is never transmitted by telephone.

It may not be amiss to mention that, after the infant has been sent to the nursery, its necklace is fastened to the front of its dress by a tape, so that when the nursery nurse takes the infant to its mother she always reads the name from the necklace and compares it with the mother's bracelet. This is especially helpful at night, when a sleepy mother is likely to answer to her neighbor's name instead of her own name.

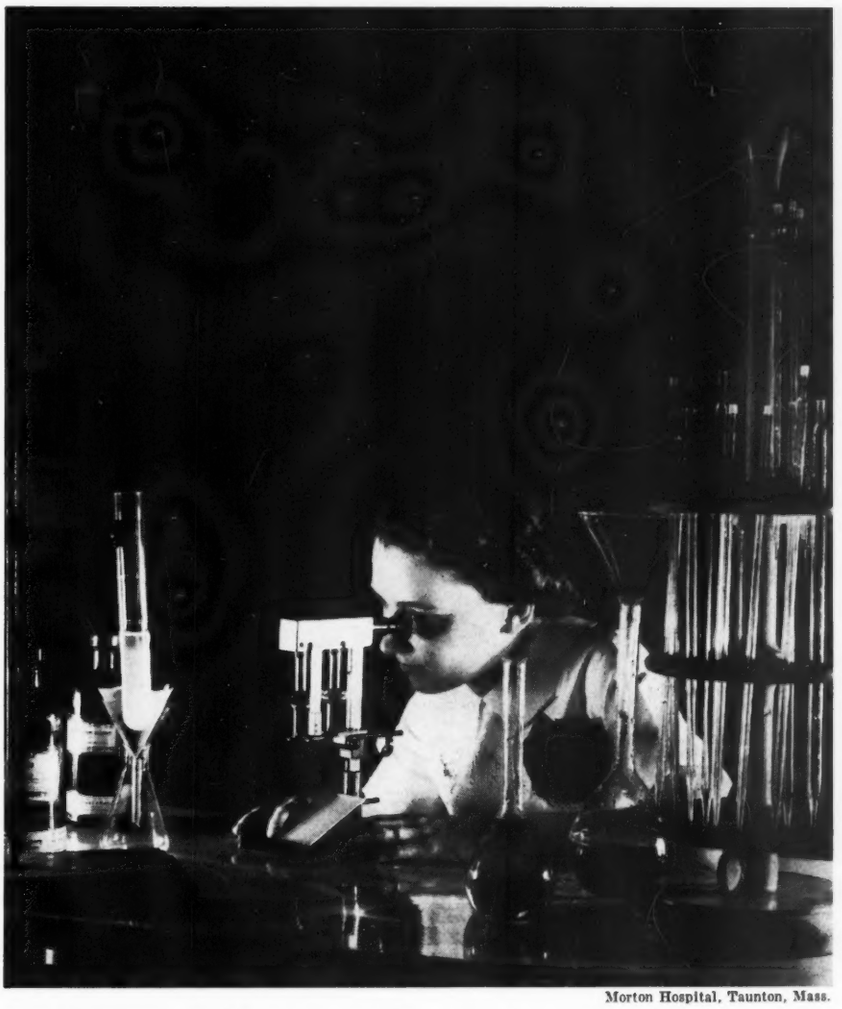
When these preliminaries have been completed, the patient is transferred by stretcher to the labor room where the charge nurse accepts her and the chart and checks the identification on the bracelet. It is the duty of the charge nurse to attempt to judge, insofar as possible, the activity of the patient's labor and assign her accordingly. The primary objective is to segregate the patients so that women who are not in active labor will not have to see and hear those who are in labor.

From an address to the American Congress of Obstetrics and Gynecology, October 1939. Miss Konrad is assistant superintendent and director of nurses at the Margaret Hague Maternity Hospital, Jersey City, N. J.

Why Waste Patients' Money—

on a Complete Blood Count?

W. D. STOVALL, M.D.



Morton Hospital, Taunton, Mass.

Sometimes expensive laboratory procedures creep in as a part of routine practices.

AMONG the most familiar letters in the clinical records of patients in hospitals all over the country are "C. B. C." They are an abbreviation of a longer order and, therefore, are a boon to interns and residents alike whose communications to consulting services are recorded in symbols as numerous as the signs of the zodiac. Most of these notations refer to laboratory procedures and are used in profusion lest something be missed.

The requests for total blood counts are probably used in a routine way more frequently than is any other laboratory determination except the examination of urine. Almost without exception, every patient who enters a hospital has blood drawn for a total red cell count, total and differential leukocyte count and hemoglobin determination, regardless of the significant findings in the history and physical examination and frequently before any of this information is obtained. It appears to be done without thought of the significance of any of these data.

Indeed, staff members with whom I have talked about this wasteful habit have given many reasons for it, none of which seems to warrant the practice when the increased cost of medical care is considered. I have been told that once upon a time a case of pernicious anemia was picked up that would otherwise have been missed; then again, that the clinical record of the patient is not complete without a record of the C. B. C.

The initial complete blood count, however, is not the only one the patient is likely to receive. At least once a week during his stay in the hospital the intern will order C. B. C.

This, we must suppose, is a precautionary measure to prevent the patient from being discharged with a leukemia developed after he came into the hospital or to pick up a latent infection or undiscovered anemia that none of the professional attendants could have otherwise been led to suspect.

Rarely do patients who need certain hematologic studies during the course of an illness have only those that are needed to follow the reaction of the patient's blood forming organs to his particular disease. The intern usually orders C. B. C. and, although it is wasteful of laboratory time and material, it is quick and easy for him and he is sure that some of the report will be what is required.

To fail to consider the significance of each of the determinations in a total blood count not only is wasteful but develops carelessness in methods of practice and accounts for failure to recognize the importance of physiology in diagnosis. The routine use of any laboratory tests creates the impression that there is some specific clinical picture brought out in the results and gives the student the impression that medical diagnosis is nothing more than familiarity with certain characteristic symptoms, signs and laboratory results for each disease.

No teacher, of course, intends to convey such an impression. Rather, he

The author is director of laboratories and acting superintendent of the Wisconsin General Hospital, Madison.

attempts to point out the importance of the association of certain laboratory studies with the symptomatology and physical signs for the purpose of determining the nature and extent of the disease and sometimes the methods by which it is to be treated. With but few exceptions, this kind of study cannot be accomplished by routine laboratory orders. Routine urinanalysis is one of the exceptions.

Duplication and Wasted Effort

When the physiologic or pathologic significance of the results of a complete blood count is reviewed, the duplication, waste and loose thinking involved in the routine use of these tests are immediately apparent. C. B. C. signifies that the physician wants a report from the laboratory on the total number of red cells and leukocytes per centimeter of the patient's blood, a differential count of the leukocytes, and the number of grams of hemoglobin, usually expressed in per cent of normal, in each hundred cubic centimeters of the blood.

Since the production of red cells is a function of the bone marrow and the amount of hemoglobin is dependent upon the total number of red cells and an adequate supply of iron, it is obvious that the hemoglobin determination alone is adequate as a routine method for checking that function of the bone marrow which has to do with red cell production and hemoglobin formation. If there is no anemia, it is likely that the patient has neither a low red count nor an iron deficiency.

If the hemoglobin is low, then further studies are required. It may be important to know whether there is a reduction in the red cell count and how much; whether the anemia is macrocytic or microcytic. Several laboratory determinations that are important in the recognition of various types of anemia may then be required. If the physiology of red cell production and hemoglobin formation is kept in mind, each test will have a special significance. Unless these tests have some special importance in clarifying the diagnosis, giving a clue to the prognosis or in following the progress of the patient under treatment, there is no reason for doing them. The history and physical examination of the patient should be of great significance in determining how far the laboratory tests should go.

However, it should be emphasized that if the hemoglobin measurement is to be useful it must be done accurately. In the past, hemoglobin determinations, while a part of routine diagnostic procedures, as a rule have been worse than worthless because many of the instruments were grossly inaccurate. There now are several that have been carefully standardized and give accurate readings in the hands of careful technicians. I prefer instruments that use the photo-electric cell because they eliminate the variability of the human eye in its reaction to color.

The total and differential leukocyte count as a routine procedure occupies a position similar to the red cell count and hemoglobin determination. When we remember that we seek to determine both the quantitative and the qualitative reaction of the bone marrow and the lymphoid tissue of the body, it may seem important to include both of these as routine. But if we consider the significance of each method carefully, it is apparent that the two are not necessary and a choice is clear.

The total count alone reveals only the quantitative reaction, *i.e.* the total number of leukocytes without reference to kind or to the age of the cells. The examination of the stained smear, on the other hand, gives the trained and experienced worker a rough idea of the quantitative reaction and also an opportunity to observe the quality of the reaction. The total number of leukocytes alone has little value. In following cases in which bone marrow reactions are an important guide to therapy and prognosis, it is always necessary that both total and differential counts be done.

For those patients who have not been thoroughly studied and for purposes of pointing out lines along which further study of the patient should proceed, it seems that the differential count is all that is needed and that for the time being the total leukocyte count could be dropped from the routine procedure. This viewpoint, it seems to me, is strengthened when we consider that the differential count is done with stained blood smears and they afford an opportunity to observe the quality of the red cells as well as the leukocyte production.

When consideration is given both to medical cost and to medical diagnosis, it is important that every effort be made to lower costs to the point consistent with good medical practice. This often is not done because many unnecessary and expensive laboratory and other procedures creep in as part of routine practices. This not only increases hospital costs, which both the physician and the hospital would like to reduce, but brings about the misuse of instruments of precision and develops loose methods of thinking on the part of students, which undoubtedly account for many missed diagnoses.

I believe that an accurate hemoglobin determination and the study of a stained blood film for the quality of the leukocyte and red cell reaction are all that need to be done in the way of routine in the field of hematology, and that all other tests and determinations should follow as special work required for the individual case. If this were done, much time that is now put in on hurried routine tests could be devoted by the laboratory technicians to special study determination. While I have used the C.B.C. as an example of waste and loose thinking in our diagnostic methods, many others could be cited.

Free Care for Employes

The policy of charging hospital employes for medical care during illness, based on the argument that they would have to pay if they were working in a hardware store, is shortsighted. Here is an opportunity for the hospital, at small cost to itself, to repay the worker with kindness at a critical time, in return for the kindnesses that he himself has shown to the sick. There is a wholesome quality to such a practice. The employe who has been so favored will, literally, eat out of your hand, while the one from whom you would turn during his illness may bite the hand that feeds him.—E. M. Bluestone, M.D., *Montefiore Hospital.*

Job Combinations

Found Practical in 15 Hospitals

MANY employes in small hospitals must handle two, three or sometimes four different jobs. This requires a greater degree of flexibility, more all-round ability and wider interests than exclusive specialization in one position requires.

The person who does the most combining, of course, is the administrator. Women administrators in small hospitals serve as anesthetists, dietitians, housekeepers, purchasing agents, admitting clerks, bookkeepers, record librarians, superintendents of nursing, laboratory and x-ray technicians and other department heads as needed. Men administrators usually do not cover as wide a range but frequently take on engineering and similar duties that are not advisable for women.

There is considerable feeling in the field that many administrators are carrying on so many detailed activities that they are forced to neglect the more important administrative and public relations activities of their institutions. The best solution of this problem seems to lie in employing department heads who are capable of handling several activities, thus permitting the administrator to devote more time to more important duties.

This need is being increasingly recognized by educational institutions but the trend needs still further encouragement.

Housekeeping is most often combined with either dietetics or nursing, and there is considerable difference of opinion in the field as to which combination is better. Pharmacy is often combined with purchasing and with service as a technician in the pathologic and radiologic laboratories. Medical record librarians often serve also as laboratory technicians, as admitting officers or as secretaries to the administrator and business office. Anesthetists may also be record librarians and laboratory technicians.

The following comments from administrators of small hospitals indicate their views on this subject.

RL + Ad

● Our medical record librarian is being trained to act as an admitting clerk as soon as she has mastered her records work here.—GLADYS BRANDT, *Cass County Hospital, Logansport, Ind. (58 beds).*

RL + T

● We combine the work of the laboratory technician with that of the medical record librarian. This woman attends all medical staff meetings, obtains histories and checks up on the doctors to get their records written up.—BEATRICE V. MURRAY, *Mary Lane Hospital, Ware, Mass. (35 beds).*

RL + C

● The record librarian takes over the duties of chief clerk every third Sunday. The assistant librarian serves also as general secretary to the credit manager and superintendent.—HARRY C. SMITH, *Manchester Memorial Hospital, Manchester, Conn. (55 beds).*

A—Administrator
Ad—Admitting Clerk
An—Anesthetist
C—Chief Clerk
D—Dietitian
En—Engineer
H—Housekeeper
N—Superintendent of Nurses
P—Pathologist
Ph—Pharmacist
PA—Purchasing Agent
RL—Record Librarian
St—Storekeeper
T—Technician

A + D + H + PA

● I serve as dietitian, housekeeper and purchasing agent, as well as administrator. We have a set menu but make substitutions when the patient objects too violently to what is offered. I direct the housekeeping and do all of the purchasing for the hospital. A small hospital administrator must be a "Jack-of-all-trades."—MARY MONGEAU, *District Hospital, Webster, Mass. (25 beds).*

H + N

● I do not believe that it is desirable to combine the work of housekeeper and dietitian since this causes a conflict between this person and the superintendent of nurses. I have found it better to have all of the housekeeping done under the direction of the nursing supervisors on each floor. Our dietitian does handle all the linens and also has charge of the yard man.—JEWELL W. THRASHER, *Frasier Ellis Hospital, Dothan, Ala. (64 beds).*

En + H

● Recently, we made the chief engineer head of the housekeeping department, which gives him supervision of five maintenance men, some of whom are relief engineers, and also of six housekeepers. We have four buildings that are independent of the hospital itself, each of which requires the services of a housekeeper. Previously, the housekeepers came under the direct supervision of the superintendent of nurses. We found that the maintenance men fre-

quently were required to make miscellaneous repairs and do some of the heavier cleaning. Therefore, we thought it advisable to place housekeeping under the direct supervision of the chief engineer in order to maintain more efficiency in the distribution of that type of personnel.—HARRY C. SMITH, *Manchester Memorial Hospital, Manchester, Conn. (55 beds).*

D + H

● Our dietitian takes charge of all the women personnel. She supervises the maid service in both the nurses' home and the hospital. I handle all the men employes, the maintenance crew, orderlies and others. I approve all requisitions for repairs and replacement, as well as for renovation, painting and general upkeep.—ELIZABETH MILLER, *Paul Kimball Hospital, Lakewood, N. J. (75 beds).*

D + H

● At present we have neither a housekeeper nor a dietitian but I am looking forward to the time when I can have a person to manage both jobs. There is not enough work in either department to justify the full time of a qualified person.—EDNA PRICE, *Emerson Hospital, Concord, Mass. (38 beds).*

D + H

● The dietitian in a small hospital should have the most practical training. Household management should be a definite part of it. I have a student dietitian who was trained at Brantford General Hospital, Brantford, Ont. This girl has enjoyed having the opportunity to gain an all-round experience. The dietitian is one of our most important people from the standpoint of building good relations with patients.—MARJORIE BUCK, *Norfolk General Hospital, Semcoe, Ont. (38 beds).*

P ÷ 4

● We have a pathologist who also works for three other hospitals. With his salary split four ways it doesn't cost any of us too much. He devotes every morning to our hospital and goes to the other hospitals in the afternoons. This is satisfactory to all the institutions. The volume of laboratory work has increased by 10 or 12 per cent since the idea was first put into practice. We have been able to install an x-ray therapy machine and to employ two laboratory technicians. The hospital has just spent $2000 to modernize the laboratory to meet the increased demands upon it. Except for a certain proportion necessary to cover administrative and overhead expenses, all earnings of the laboratory are turned back to this department to improve the equipment or the service. We hope to develop a cancer clinic for this area.—GLADYS BRANDT, *Cass County Hospital, Logansport, Ind. (58 beds).*

An + RL + T

● When a nurse anesthetist is employed in a small hospital, the situation is somewhat different from that in an institution that requires a large staff. In view of the fact that there is but one anesthetist in the small hospital, she should have an adequate amount of training and experience because she alone will be available for all types of cases. She should be a graduate of a school of anesthesia conducted by a hospital that offers a wide variety of surgical cases and utilizes all the anesthetics that are accepted today. A good theoretical training in anesthesia is essential. In order to be fully prepared for the position of sole anesthetist in an institution, she should obtain a wider practical knowledge after graduation by taking a position for at least two years as junior member of a well-organized anesthesia department in a large hospital.

In a small hospital requiring comparatively few anesthesias, the nurse anesthetist can combine her work successfully with that of hospital superintendent, record librarian or x-ray technician. Keeping records would probably be the ideal supplementary part-time work.—ESTHER MEIL, *anesthetist, Henry Ford Hospital, Detroit, Mich. (600 beds).*

Ph + T + PA + St

● Our pharmacist is also the relief technician in the x-ray department. She is a graduate of Purdue University and is well trained in pharmacy. On the basis of this training she has also been able to take over several other duties. She teaches materia medica to the student nurses and acts as purchasing agent and storekeeper. The dietitian purchases the food and the pharmacist does all other purchasing. Both of them consult with me in regard to the larger items. I approve all purchase requisitions. Salesmen who call on me are also referred to the pharmacist or dietitian.—VERNON T. ROOT, *Rockford Hospital, Rockford, Ill. (84 beds).*

D + H

● I think that the housekeeper-dietitian combination is a good one for small hospitals. Of course, the success of all such combinations depends a great deal upon the abilities and tastes of the individuals concerned. If the dietitian does not like housekeeping, the superintendent has to do the work. But we have no friction among our employes. The small hospital administrator has an advantage in being able to know the employes individually.—KATHERINE HALL, *Wentworth Hospital, Dover, N. H. (69 beds).*

N + An

● Our superintendent of nurses acts also as relief anesthetist and as distributor of medical supplies. The anesthetist, on the other hand, has assumed the duties of assistant superintendent of nurses and of pharmacist. The second relief anesthetist is the relief supervisor and also does general floor duty nursing. The second operating room nurse serves in the emergency room. One maintenance man also serves as an orderly.—HARRY C. SMITH, *Manchester Memorial Hospital, Manchester, Conn. (55 beds).*

Misc.

● We have been able to combine several jobs in our hospital. Our janitor is also our engineer, carpenter, plumber and mechanic; our maid, besides her regular cleaning duties, handles all of the mending and sewing, and our superintendent of nurses also does general duty nursing in her spare time.—H. ALBERT TAYLOR, *El Reno Sanitarium, El Reno, Okla. (35 beds).*

"Lost and Found"

Former Mental Patients Carry Idea of Recovery to the Public

ABRAHAM A. LOW, M.D.

IN THE late summer of 1937, the staff physicians of the Psychiatric Institute of the University of Illinois Medical School in Chicago were confronted with a novel experience. Patients who had been discharged after receiving "shock" treatment returned to the hospital even after their parole period had expired. In previous years this had been a rarity; now it was a common occurrence. It was obvious that the patients' attitudes to the hospital had changed and there was no doubt that the change was the direct result of active treatment.

Heretofore, the mental hospitals had provided general care and little, if any, active treatment. If the patients recovered they owed their health to the action of time rather than to the activities of hospitals and physicians. Now the situation was changed. The recovered patients had regained their health after energetic, active treatment by the physicians. They felt indebted to them and returned to consult them when they encountered difficulties.

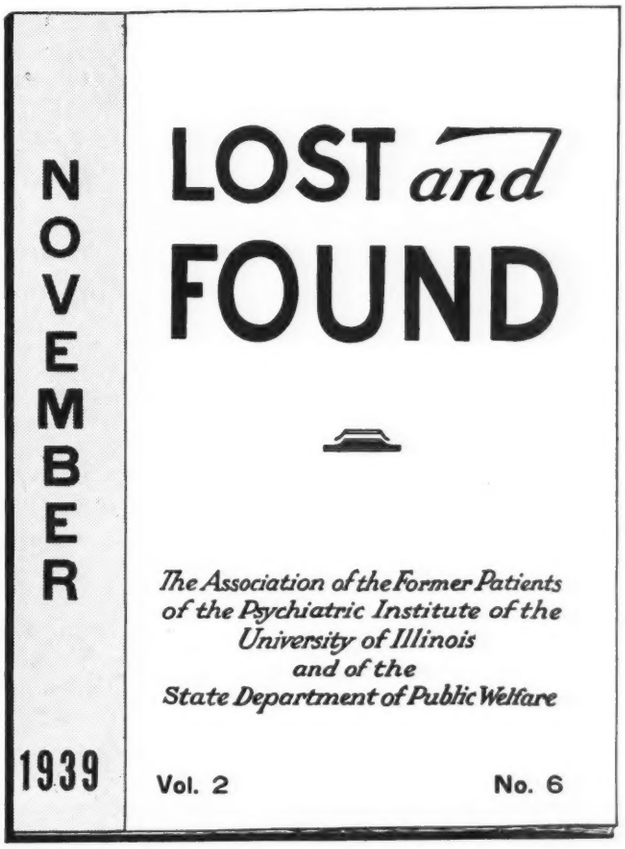
The main difficulty of the returned patients was the stigma of mental disease. The stigma had two aspects: (1) a subjective feeling of degradation on the part of the former patients, and (2) the objective discrimination encountered in their efforts to reintegrate themselves into the fabric of economic and social life.

As a result of frequent conferences with the staff physicians, 30 former patients decided in November 1937 to organize for the purpose of fighting the stigma and of promoting their economic and social interests. They formed a group called "Recovery, the Association of Former Patients of the Illinois Psychiatric Institute."

Today, after nearly two years' existence, the association comprises more than 100 former patients, as well as approximately 500 relatives and friends who are contributing members. Other associations were formed at some of the Illinois state hospitals. However, while the parent organization is flourishing, the continued existence of the state hospital units is still in the balance.

It was clear from the outset that it was the patients themselves who were to carry the issue of recovery to the public. This presupposed a fair degree of familiarity with the basic problems of mental disease and adjustment, on the one hand, and with the legal, economic and social implications of the stigma situation, on the other. A program of instruction had to be formulated and this gave the physicians an opportunity to initiate systematic after-care. The former patients, their relatives and friends met with the physicians at regular intervals and discussed general principles of adjustment.

The patients realized clearly that the stigma had many roots. However, they concentrated their efforts on the task of eliminating the main sources of stigmatization. These were: (1) the hush and secrecy policy of the patient's own relatives, which made it impossible for the returned patient to regain relaxation and self-confidence; (2) the general conception of the public that "once insane—always insane," which made it difficult for him to recover an economic and social foothold, and (3) the cruelty and barbarism of the commitment law, which branded him officially as potentially dangerous and antisocial. From these three



"Lost and Found," the unique journal of the association of former patients, is an important part of the program of recovery. In its columns are discussed such topics as "average daily misbehavior" and "self-help." The most unusual feature is the want-ad department through which ex-patients are offered employment.

Doctor Low is assistant director of the Psychiatric Institute, University of Illinois Medical School, Chicago, and president of the Association of Former Patients.

main points originated three distinct efforts of the association.

The patients insisted that their relatives be given instruction in matters of adjustment and mental disease. To this end, the relatives were asked to appear at the hospital every first and third Sunday of the month, together with the patients, to listen to a series of lectures by a physician.

At these lectures emphasis is being laid principally on domestic adjustment. The relatives' attention is called to the fact that they themselves are the principal representatives of the stigma, that they themselves are forever distrustful of the real recovery of the patient and, consequently, irritate him by their absurd oversolicitude. An effort is made to discuss such topics as temperament, disposition and domestic discord.

Parents Forced to Attend

The fact that both patients and relatives consistently request a greater amount of instruction indicates the fruitfulness of the procedure. It is undeniable that the discussions tend to fortify the patients' morale. In many instances, unwilling parents have been forced by their sons and daughters to attend the meetings and to discuss with them at home the issues presented at the hospital conferences. We have good evidence that a goodly number of parents have revised their opinions and attitudes fairly extensively.

The endeavor to influence the attitudes of the relatives is essentially a step toward influencing the public. As one of our patients remarked, "More than 6000 patients are committed to the Cook County Psychopathic Hospital every year. If we campaign among their relatives we shall soon reach every family in Cook County." However, the association realized that the public had to be contacted without reference to the fantastic hope of enrolling as members all or most of the relatives of Cook County's patients.

In the spring of 1938, the association was invited by the Illinois Society for Mental Hygiene to join in its radio activities. Three radio talks were delivered in the form of dialogs between a former mental patient and a staff physician of the Psychiatric Institute. These were followed by a series of six public lectures on "What the Relatives of Mental Patients Ought to Know About Mental Disease." Both in the radio talks and in the discussions following the public lectures, the former patients had an opportunity to speak publicly about their difficulties and hopes. It was, to our knowledge, the first endeavor of its kind to make former patients and their relatives air their problems in public. Both the moral and financial effect of the public lectures—there was a substantial net profit—induced the executive committee to arrange a public show with a former patient taking the stage as professional magician.

As the direct result of these public activities, men and women of social prominence became interested in the activities of the association and promised their active support for the fall program. The latter was planned on the principle of self-help. The underlying theory is that if the former patient is to conquer the stigma he must demonstrate to the community that he is able to manage his own affairs; in other words, that he has really recovered. In the spirit of self-help patients, assisted by physicians, are addressing churches and club groups and are presenting the issues of the association.

The former patients are determined to eliminate the court from commitment proceedings. A committee of leading lawyers and university professors has prepared proposed legislation for the new session of the Illinois legislature. The subject has been amply discussed in the various issues of *Lost and Found,* the unique and already widely known bulletin of the association. There seems to be unanimity among the competent members of the legislation committee as to the feasibility of the contemplated legislative changes.

Lost and Found, the bi-monthly periodical of the association, has a steadily increasing list of subscribers, particularly among colleges, libraries, hospitals, individual physicians, psychologists and sociologists. The reason is not merely the human appeal exercised by the cause of the former mental patient but also the striking manner in which the issues of mental disease and stigmatization are treated in its pages. Space does not permit detailed description beyond stating that "average daily misbehavior" is the main topic. Of late, the subject of self-help has been prominently featured.

In general terms, the principle of self-help already has been expressed in the fact that the association, composed largely of economically dependent members, covers its expenses comfortably. During the last business year, the association's income was approximately $1800. It was also in line with the spirit of self-help that patients spoke over the radio and arranged public meetings and a public show. More important developments, however, have recently taken place. One day a discharged patient, a shoemaker by trade, arose during a semimonthly meeting and requested those present to let him do their shoe repair work. Thereupon, another former patient offered his services as a photographer and still another, as handyman. The success was instantaneous. The three pioneers received orders sufficient to supply a welcome addition to their income.

These Want Ads Unique

At a subsequent meeting, the father of a patient offered to employ a suitable former patient in his machine shop. The mother of a patient employed another one to take care of her child. The aunt of a patient took an out-of-town member, just paroled, into her house, asking in exchange nothing but assistance with the housework. A former patient had her spring housecleaning done by a "colleague."

As an upshot of this development it seemed advisable to create an advertising column in *Lost and Found* for the purpose of exchanging work and services. Advertising space is offered free of charge to patients in search of work and to employers offering employment.

Recently, the husband of a discharged patient advertised for an office girl, with the proviso that "applicant must be a former mental patient." An item of this kind has perhaps never appeared in any other advertising column.

Is This Your Secretary?

VIRGINIA BLOCKER, M.D.

MISS MASON is a "career girl." She wears what the well-dressed secretary should wear and has read in all the magazines what not to do. She does not powder her nose in the office or show her knees or chew gum, and the handsomest young intern is just an item in the hospital inventory to her.

Miss Mason takes a real interest in her work. She reads the medical

and hospital journals in her spare time, and she can carry on an intelligent conversation on almost any subject from sterilizing equipment to vitamin K.

You sometimes wonder about Miss Mason. She knows the rules of ethics, and yet in some way or other the news leaked out that one of the city's most prominent business men was being treated for early paresis and that a certain young staff member had been "called on the carpet" for neglecting his work. Only yesterday, newspapermen telephoned for details about a miraculous cure that had been performed on a hospital patient "said to be suffering from a rare disease of the blood."

Perhaps Miss Mason takes too much interest in her work.

MRS. ABBOTT, your hospital being a small one, is your "right-hand man." She runs the switchboard and handles mail and admits patients and keeps books and issues housekeeping supplies and answers letters and orders groceries for the kitchen.

Of course, sometimes things do get in a mess. Every once in a while Mrs. Abbott forgets to send for special duty nurses, and the books are always a little off balance. Once the letters and orders got stacked up for two or three weeks and the operating room ran out of suture material, but that was an exception. Another time Mrs. Abbott got mixed up and ordered 100 sacks of brown sugar instead of white, and 20 cases of artichokes instead of asparagus, but she had a cold that day and wasn't feeling well besides.

Usually Mrs. Abbott gets nearly everything right but, in spite of the fact that she takes the place of several employes, you never seem to be able to make ends meet. Every day, for some reason you can't figure out, the hospital goes farther and farther in debt.

Someone made the suggestion the other day that it might be false economy to employ Mrs. Abbott as a Jack-of-all-trades. You have been giving the matter some serious thought. Perhaps, after all, she is a liability instead of an asset.

MISS GEORGIA BEAL is the niece of one of your chief benefactors. Year before last she was the most glamorous debutante of the season. Last year she did social service work in the slums two hours a week. This year she decided to become a working girl and, after seeing a couple of movies depicting the heroism of "Men in White," she chose your hospital for her career, because, as she told her uncle, "interns are so terribly attractive."

Naturally, when the old man explained the situation to you, you took her on at once as your personal secretary, remembering how much you would like to have some new electric incubators for the nursery.

So Miss Georgia is now a working girl, according to her own standards, which include coming to work at 10 a.m., leaving at 4 p.m. and taking two hours off at noon for lunch in town. She has not entirely forsaken the social world, however, and is always departing early for the beauty parlor in order that she may look her best at some tea-dance or other for a visiting celebrity.

Miss Georgia is almost too beautiful to be true; no one could deny that she is an ornament to the hospital. But, of course, she cannot be expected to do much work, and you have taken to coming back in the evenings and getting the night clerk to help with your correspondence.

You sometimes wonder if the incubators will be worth it or if you really care whether the president has a stroke when you fire her.

MISS GIBSON is a good secretary. She has been to college and to business school and she was a smart girl to begin with.

She has never accidentally thrown away a check wormed by slow and painful effort from a disgruntled patient for his hospital bill. She has never slammed the telephone receiver on the irate ear of the president of the board.

Her filing system is efficiency itself and her letters are models of neatness. The margins are even to a

tenth of an inch and she knows the comma rules by heart.

Miss Gibson is a smart girl, but she has forgotten that she works for a hospital superintendent and it has never occurred to her to acquire a medical vocabulary.

In the middle of a beautifully typed page sits the word "sycopathic." The way she spells "Staphylococcus" is almost sinful. She blinks three times when you say "aortic

Doctor Blocker is assistant superintendent of John Sealy Hospital, Galveston, Tex.

aneurysm" or ask her about an order of cyclopropane and "sphygmomanometer" throws her into a panic.

There is an excellent medical dictionary in the bottom drawer of Miss Gibson's desk, but she has never used it except to keep papers from blowing away in windy weather. Wouldn't you think she would learn?

MISS COLTON would be a pretty good secretary if she were not so intent on looking for a husband. Efficiency in your office is a thing of the past. Every time you want Miss Colton she is either out for an hour having a coca-cola with some young man who ought to be writing progress notes on his patients or else obstructing traffic down the hall while she makes dates for the movies on Friday and Saturday nights.

When you do finally locate her to give her some work, she is always flustered and apologetic. But in a few moments she is staring off into space daydreaming about what she

will wear tonight or what somebody said about her eyes or how her left hand would look with a diamond perched on top.

Miss Colton is an attractive girl and has certainly proved a menace to the morale of the interns, who are now showing signs of unrest and talking about the chances of making money in general practice "right away" instead of applying for research fellowships and asking advice on specialized training.

A flirtatious young woman is the last thing in the world you want for a secretary. Yet Miss Colton's mother would have a hard time getting along without her monthly check. You can't fire her, but you certainly hope that she gets her man soon.

MRS. PLINKETT is not a good secretary any way you take her. Mrs. Plinkett is not even a pleasure to look at. She is somehow a little too well scrubbed and is so belligerently poor-but-honest that her

face wears a look of perpetual strain.

Five years ago Mrs. Plinkett left the children with the neighbors and went to night school for a few weeks, where she acquired a halting, three-finger technic. She never quite learned to make a carbon copy of a letter "on account of the erasing, you know." She can't take dictation because she never learned how to make "those little wiggles." She can't remember what people say over the telephone because she says it gets her so flustered. You don't dare send her on an errand because hospitals make her feel "fainty," and once she had an old-fashioned falling-out spell in the path of a patient being rolled to the operating room.

But Mrs. Plinkett is really a worthy woman and she has her share of troubles, as she will tell you at length if she can catch you off guard. You thank heaven that she has only two more weeks to work to pay for her husband's peptic ulcer.

MISS AINSWORTH is a secretary without a fault. She is not exactly beautiful and yet she is distinctive looking and always appears fresh and well groomed, even at 5 o'clock on a hot afternoon.

The first thing you notice about her is her voice, which is soft, modulated, clear and distinct. She never wastes words but she can soothe a long-distance complaint over the telephone or make an important visitor feel at ease immediately.

Miss Ainsworth looks after the interests of her boss. A long-winded bore never gets a chance to waste an hour of your time. She always manages to have a pressing engagement on hand for you if a caller outstays his welcome. But a business conference is never disturbed by minor interruptions. If a sink is stopped up temporarily or a patient wails that her soup is cold, these complaints are shunted off to the proper persons and you are never wearied with their trivial details.

Your appointment book is her special charge and she keeps up with everything from the hour you are supposed to arrive in Chicago next month to the date of your wife's birthday. However, if you decide from sheer perversity not to go to the barber shop on the usual day, she does not remind you of your duty or cast reproachful glances at the back of your neck. It is entirely your own concern.

Miss Ainsworth's filing system is excellent and up to date. She never

misplaces anything and she can always find what you ask for long before you lose either your patience or your interest in the subject. Her letters not only are in good form and correctly written but always sound somehow just a little smoother than they did when you dictated them, although you can never put your finger on a particular change she has made. In addition to having an excellent store of information about everybody and everything of any importance in town, Miss Ainsworth can find out anything else you want to know, whether it happens to be the name of an obscure county in New Mexico or the cruising speed of the Trans-Atlantic Clipper.

All in all, you could not get along without Miss Ainsworth. You would rather give up cigar smoking or even your morning coffee. Definitely she is a supersecretary.

Minneapolis Proves Its Case

Finds Tuberculosis Service Is of Value in General Hospital

J. A. MYERS, M.D., F. E. HARRINGTON, M.D., and T. L. STREUKENS

DURING its first year of operation, from Feb. 1, 1938 to Feb. 1, 1939, 136 patients were admitted to the special tuberculosis service of the Minneapolis General Hospital. They ranged in age from 8 to 86 years, the majority being between 20 and 60.

Of these patients 114 were immediately assigned to the tuberculosis service, 14 to general medicine, 4 to fracture service, 2 to surgery and 2 to dermatology. Thus, 22 were assigned to other services, even though tuberculosis was found to coexist with the condition for which they were originally admitted; later they were transferred to the tuberculosis service.

These 136 patients spent an average of 20 days per patient in the hospital. However, an average of only 17 days per patient was spent on the tuberculosis service, making a daily average of 6.4 in this department.

Twenty-three patients in this group were found to be free from clinical tuberculosis, 10 of whom had ordinary pneumonia which had previously been mistaken for tuberculosis. One of the advantages of this special service is promptness in differential diagnosis so that patients avoid a long stay in a sanatorium for a nontuberculous condition. There is still a stigma attached to residence in a tuberculosis sanatorium and this should be avoided unless treatment in the sanatorium is absolutely necessary.

The patients were discharged from the tuberculosis service as follows: 66 were sent to the county sanatorium at Glen Lake; 23 were terminal cases and died on the service; 12 left against advice; 9 returned to their homes on our recommendation; 15 were discharged to clinics, such as Lymanhurst and the out-patient department of the general hospital for further observation or treatment, and 11 were discharged to private hospitals or to the care of their private physicians.

Acid-fast bacilli were recovered from the sputum of 60 patients. No such bacilli were found in the sputum of 56. In others, only one or two examinations of sputum were made, for in some cases the stay was too short to make more examinations. In some, no sputum was obtainable. In 10 cases, death followed so promptly after admission to the hospital that there was not time for examination but necropsy findings confirmed the diagnosis.

Twelve patients left the hospital against advice because we had no way of compelling them to remain for the complete examination or observation since tubercle bacilli had not been demonstrated. However, among the 66 discharged to the county sanatorium, several were committed by the health department because they were known to be incorrigible and definite menaces to society.

Inasmuch as the sanatorium has no police power, the patient may desert any time after admission. However, if he is in the institution under commitment and leaves without the consent of the staff and the commissioner of health, he may immediately be sought by officers and returned to the institution. The contagious case of tuberculosis may also have a quarantine placard placed upon his door, whereupon the leaving of his room or the institution constitutes a violation of law.

The tuberculosis service in the Minneapolis General Hospital is in Hennepin County, which has a first class sanatorium with approximately 650 beds for patients with clinical tuberculosis. The demand for beds in this sanatorium has so decreased that the waiting lists of patients ten years ago have been converted into lists of vacancies; in fact, space for 50 beds has been closed in the last two years and there are still vacancies. The small tuberculosis service in the general hospital is not a duplication, as the year's work in this service has demonstrated, but is a supplement to the county sanatorium.

No attempt is made to retain patients over long periods of time. It is a teaching service and an occasional case may have his discharge postponed for this purpose. However, the average length of stay for the first year was only seventeen days. In short, this department takes cases from the hospital that are presented to the admitting department for immediate relief; patients who get into the hospital for other conditions but have coexisting tuberculosis; patients suffering from hemorrhage who can be brought from the home within a few minutes after the hospital has been notified, and patients who come in for differential diagnosis.

Thus, this service is used as a clearing house. Those who do not have tuberculosis but some other noncontagious lung condition, such as malignancy, are transferred to the appropriate service promptly. Those who have tuberculosis in the terminal stage and are near death on admission are allowed to die in the hospital; those who have tuberculosis that is thought to require a long period of treatment are transferred with a reasonable degree of promptness to the sanatorium, provided they will accept such care. In a single

The authors are associated with the Minneapolis General Hospital, the Lymanhurst Health Center and the departments of medicine and preventive medicine of the University of Minnesota. The paper was prepared with the aid of a grant from the research fund of the University of Minnesota.

year, we transferred more than five patients each month to the sanatorium.

This service also is used to isolate transients. During the year we admitted frank cases of tuberculosis in a contagious stage from parts of the state outside the jurisdiction of the general hospital, from other states and even from other nations. They were retained on this service until care could be provided for them in the places from which they came or some special provision could be made for them. Thus, they were not permitted to spread their disease to the citizens of Minneapolis, after it was known to exist.

In a few of our cases artificial pneumothorax was instituted soon after they were admitted to the institution to stop hemorrhage, to render the sputum negative for tubercle bacilli or to prevent it from becoming positive. We have not employed chest surgery on this service because the stay of the patient is too short and the county is equipped to care for them.

Used as Teaching Service

The Minneapolis General Hospital is a teaching institution affiliated with the schools of nursing and medicine of the University of Minnesota. Moreover, it teaches certain phases of nursing to the students of several other hospital schools. Since the hospital has assumed this obligation it should not fail to make provisions for instruction in the disease that still stands first as the cause of death between the ages of 15 and 45 years. A large service is not necessary to do such teaching adequately, since the students come to us in small groups and since there is such a variety of material owing to the rapid change of patients on the service.

During the year we have been able to demonstrate to our students of nursing and medicine every significant phase of tuberculosis from the first infection type in a child of 9 years to the slowly progressive reinfection type that took life at 89 years. Such nontuberculous complications as pregnancy, diabetes and malignancies, as well as extrapulmonary tuberculous complications, have been available for teaching. An average of six patients provides abundant teaching material for the students of this hospital. A greater number of patients would for the most part serve only to duplicate material.

Progress in Diagnosis

The recent advances in diagnosis can be demonstrated with a small group. For instance, we have long since learned not to accept diagnoses from the x-ray laboratory alone as final; the roentgenologist sees only a shadow. On a number of occasions patients have been sent to us with definite diagnoses of tuberculosis made in the x-ray laboratory, which proved to be due to other conditions. This serves to impress upon the students that if men of long years of experience in interpretation of x-ray films make such frequent errors, the x-ray examination alone is not infallible. The point is emphasized that no single phase of an examination justifies a diagnosis; even the finding of acid-fast bacilli in the sputum is not enough, since not all such organisms are tubercle bacilli.

The interns of the entire hospital rotate through this service. They not only actually carry out the various diagnostic procedures but are taught to administer such treatments as artificial pneumothorax. They are impressed with the contagiousness of the disease by the technic that is employed throughout the service. Once a month the interns present the interesting cases at a special staff meeting.

No patient should be sent to a sanatorium unless a definite diagnosis of tuberculosis has been established. There is good evidence that exposure of adults to contagious cases is hazardous. We do not know whether it is more so if the individual has never been previously infected but we do feel that first infection and reinfection should be prevented.

Certainly the uninfected who are sent to a sanatorium for observation and become infected with tubercle bacilli while they are there have a justifiable complaint against the institution. A good example is that of a girl of 15 years, who was admitted to the Minneapolis General Hospital on Nov. 28, 1933, because of a pulmonary hemorrhage. There was no tuberculosis service in the hospital at that time and, even though her sputum contained no tubercle bacilli and she did not react to tuberculin, she was sent to a sanatorium. The process responsible for the hemorrhage proved to be nontuberculous.

The girl's mother was fearful of having her daughter in a sanatorium and requested that she be kept isolated from other patients. This was done for a time but after about six months in the institution she was transferred to a ward where she was in contact with advanced cases of tuberculosis with tubercle bacilli in their sputums. In August 1934, she was found to be a strong reactor to tuberculin. Her mother immediately demanded that she be removed from the institution and since that time we have had considerable difficulty in convincing the mother that she should not bring legal action against the institution or the physicians individually, whom she considers responsible for permitting her daughter to become infected.

If there had been a tuberculosis service in the Minneapolis General Hospital at the time the observations on this girl could have been completed in a short time under a strict contagious disease technic. We have seen patients sent to sanatoriums for observation who were retained from six to twelve months before it was finally determined that they did not have clinical tuberculosis. Time is too important to the patient and the operation of an institution is too expensive to the community to have patients retained this long.

Nontuberculous Cases Diagnosed

The advantages of our service are shown by the following instance. A mother was strongly suspected of having pulmonary tuberculosis because of recent hemoptysis. She was admitted to our service for diagnosis. A few days later her 16-year-old daughter was also admitted because of hemoptysis. On examination it was found that neither of these persons had pulmonary tuberculosis and the bleeding was from an entirely different source than the lung. Both of these patients would in all probability have been sent to a sanatorium had our service not been available. From the standpoint of affording

immediate protection to the community, we find that 23 moribund cases were promptly hospitalized and thus prevented from spreading their tubercle bacilli as long as they lived. Thus, the community was definitely protected. We find also that 37 other patients with tubercle bacilli in the sputum were immediately taken out of the community. In the hospital proper, 17 persons with previously unsuspected tuberculosis were found to have this disease co-existing with the condition for which they were admitted.

Method of Control

The methods of protection that have been most discussed are attempts at immunization with B.C.G. and the adoption of a contagious disease technic.

We have not employed B.C.G., as has been done in some places, because we do not feel that the results of all experiments with this method combined have proved in anything like a conclusive manner that it is an adequate preventive measure. It is true that it sensitizes and thus establishes the "fixing power" of the tissue; so does an infection with virulent tubercle bacilli, but in such organs as the lungs this is a distinct hazard when reinfection occurs.

The remote effects are the important ones and these have scarcely even been considered. The fact that the veterinarians of this country employed B.C.G. in an attempt to prevent tuberculosis in cattle and found it so woefully wanting that they completely discarded it has also aided in the establishment of our conclusions. Moreover, since it sensitizes the tissues, it renders subsequent detective work through the tuberculin test impossible. Therefore, one can no longer proceed to assemble evidence for the development of the only sound and fundamental method of tuberculosis control, namely, the prevention of infection with virulent tubercle bacilli.

The tuberculosis unit is an integral part of the communicable disease service. There are three wards of five beds each, in two of which glass cubicles separate the patients.

Each patient is cared for under individual unit technic throughout his period of hospitalization. As in the case of any other contagious disease, the unit is a sharply defined zone of contamination in which all surfaces are considered contaminated. This includes walls, bed, bedside table, chair and any other article that may be left within the unit. All personal equipment, such as thermometers and bath basins, are, of course, individual.

The nurse puts on a clean gown (long sleeve, tight cuff type) for each patient during the routine care in the morning. This gown she wears wherever she is giving *any* care that makes it necessary for her to remain in the unit longer than it takes to place something on the table. She puts on this gown with the same careful technic that she uses with the other contagious diseases, making sure that the inside remains clean. If the patient's sputum contains tubercle bacilli, she discards the gown into the laundry immediately and obtains a fresh one for use for the next patient. Physicians, laboratory technicians and other workers all wear clean gowns each time they have contact with any patient. Masks, similar to those worn in the operating room, are used by all workers who go into the wards for any purpose. These also are put directly in the laundry when they are removed. The hands are scrubbed two minutes with soap and water after the gown is removed. No other disinfectant is used.

Strict Isolation Maintained

No contact between patients, such as the sharing of magazines, is permitted at any time. When bacilli are in the sputum or there is much expectoration, the patient is asked to wear a mask while any worker is in close contact with him. Dishes are boiled for twenty minutes before they are washed; linen is sent in clean hamper bags directly to the washers in the laundry where it is sterilized in the same manner as the other linen from the communicable disease service. Waste food, left on the patient's trays, is wrapped in paper and burned, if solid, or poured into the contaminated hopper, if liquid. An incinerator on each floor facilitates the burning of all waste paper, nasal wipes and sputum containers. Floors throughout the department, including clean halls, are considered contaminated.

When the patient has been discharged, the mattress is wrapped in a clean cover and sent to the roof where it is exposed to direct sunlight and air for at least six hours. Facilities for autoclaving the mattress are available whenever greater degree of contamination than usual makes it necessary. Bed, table and chair are washed thoroughly with a solution containing an abrasive powder and powdered ammonium chloride. Walls and floors are washed also and the entire unit left to air for twenty-four hours.

It would be desirable to avoid placing a patient with negative sputum in a ward where there are others who are positive, but the limited number of beds makes it necessary to put them in the same ward at times. Individual technic is, therefore, absolutely essential for the patients' protection.

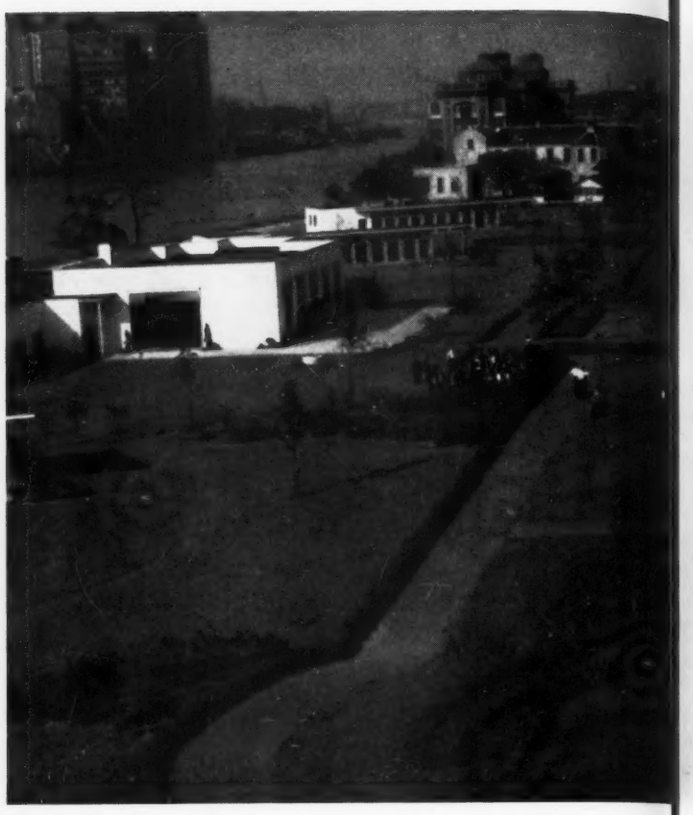
For artificial pneumothorax treatments, patients are taken to the dressing room and to the x-ray department in the same way as patients with other contagious diseases are taken through clean areas, on a stretcher completely covered by a clean sheet.

Few Visitors Permitted

Visiting is not permitted routinely. Relatives of any patient whose condition is critical are, of course, granted permission to see him. Visitors always wear gowns and masks and do not come in any closer contact with the patient than is necessary to carry on a conversation. Only for some special reason is any visitor granted a pass to see a patient whose condition is good.

Some persons express amazement that patients with contagious tuberculosis are not allowed to have regular visitors, quite forgetting that in times past the majority of tuberculous patients changed climates while the disease was being treated, thus making it impossible to see members of their families and their friends. Some patients are so desirous of avoiding the visitations of relatives and friends that they seclude themselves while under treatment. The majority of patients are reasonable persons and are willing to undergo the necessary isolation in a hospital or sanatorium to prevent relatives and friends from contracting their disease.

Right: The convalescent day camp occupies 13 acres of beautifully landscaped grounds on Welfare Island, New York. Below: A bridge foursome enjoys a game while a kibitzer looks on.



Day Camp for

GEORGE KOJAC, M.D.

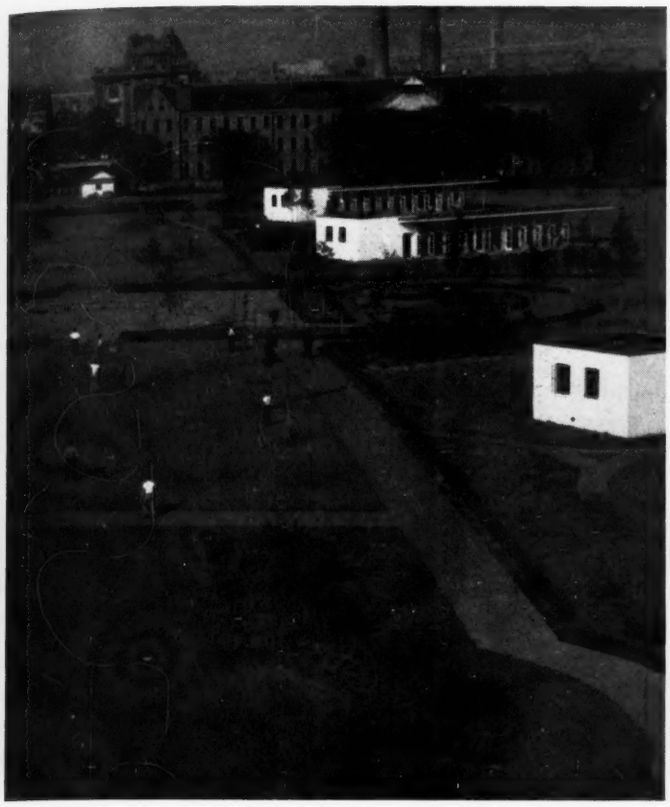
AFTER acute illness comes convalescence. What does convalescence mean? For the well-to-do patient, it is a period in which physical and mental strain is carefully avoided; in which, if necessary, diet is medically controlled, while rest and mild forms of recreation are assured either in a comfortable home or in a chosen health resort.

For the poor in New York City, the period of convalescence is not necessarily a problem period because it often brings into play the resources of carefully equipped and medically supervised convalescent homes conducted by charitable organizations whose private resources are in many instances supplemented by municipal subsidy.

There are, however, serious obstacles to the utilization of free convalescent homes. The services of these institutions are subject to limitations of age, sex, disease and capacity. But this is not the only difficulty; many convalescents, social workers tell us, cannot or will not accept institutional hospitality when it is offered to them. There are women just out of hospitals who cannot be persuaded to remain away from their husbands and children any longer; there are frail children from whom anxious parents will not part. These groups create a serious problem in medical administration. Medical social workers have long been conscious of this twilight zone in convalescence.

The convalescent day camp of the department of hospitals, conceived and created by Dr. S. S. Goldwater, the commissioner, introduces a unique and appealing service, providing convalescent facilities and care for children and adults in an outdoor environment and with modern facilities and equipment.

Every day for medically prescribed periods of time, the camp receives as its guests children and adults who will not or cannot leave home, individuals who linger uncertainly and precariously just beyond the door of the hospital, not yet fit to resume their normal stations in life. To this large group, the convalescent day camp offers a place where sympathetic understanding awaits them; where instruction and help in dieting can be obtained; where protection against personal annoyances is assured; where restful hours may be enjoyed outdoors; where river traffic and scenery offer a form of diversion, and where suitable graduated exercises and restorative occupations are provided and supervised.



Below: Comfortable reclining chairs invite patients to relax and rest in the sunshine. Bottom: A croquet game provides entertainment for both the players and an interested audience.

Convalescents

Physician-in-Charge
Convalescent Day Camp
Welfare Island, New York

The camp occupies a tract of 13 acres of beautifully landscaped grounds on Welfare Island, on which have been erected eight special concrete bungalows carefully planned with respect to scenery and view. They can be entirely enclosed and are equipped with adequate heating facilities. There is a decorative mall; side paths connect the various bungalows. The area around each bungalow is so landscaped as to give it the appearance of a separate unit, yet it is so laid out that one is conscious of a definite family and community relationship. The river on each side offers a new kind of interest for many who have never had the privilege of being so close to the shores of Manhattan. The effect is one of cheerfulness and comfort.

The centrally located administra-

tion building contains offices, a fully equipped treatment room, storerooms and a spacious dining room that can be converted into a recreation hall with facilities for staging plays and other entertainments.

One of the innovations of the camp is a wading pool. The charming outlook of the dining room upon the pool and flowery greens offers much to make lunch a happy event.

At the suggestion of Doctor Goldwater an intersectional committee representing convalescent care, medical social service and family service was organized to serve in an advisory capacity. It has been of great assistance in establishing the *modus operandi* and in furthering public relations.

The personnel of the camp consists of a physician in charge, a medical social worker, a chief nurse, a senior dietitian and a cook. The remainder of the staff is made up entirely of W.P.A. employes, including 13 recreation teachers trained in the care and supervision of convalescent patients.

The camp season for this year extended over a period of four months, from July 10 through October 31. The camp was open six days weekly, Sunday excluded, from 10 a.m. to 6 p.m. Two days, Monday and Thursday, were reserved for admissions.

All referrals for admission are made through a hospital by a social service worker. Applications are made by telephone, at which time the hospital worker gives a rather detailed history and a plan of treatment as advised by the referring doctor. The patient is referred on the appropriate admitting day with an application blank containing pertinent social and medical data.

The lowest age limit has been set arbitrarily at 12 years; no upper limit has been established. All patients must, of necessity, be ambulatory. As to the clinical types of patients eligible for admission, it has been the policy to afford the opportunity to receive needed extension of medical care to as great a number of patients as possible. Convalescents who would ordinarily be eligible for admission to convalescent homes are accepted and there is no discrimination as to race, color or sex. However, four clinical groups are excluded for obvious reasons: active pulmonary tuberculosis; cardiac cases, classes 2B and 3; contagious diseases, and mental disorders.

Transportation is provided by the referring agency. Recently the department of welfare arranged to provide carfares by means of a single relief authorization. Ten hospitals in Brooklyn, both public and voluntary, recently combined their financial resources to charter a bus. Patients living in the various sections of Brooklyn, who otherwise might be unable to attend the camp, were provided with a convenient system of transportation to and from the camp.

A group of patients "weigh in" as part of the medical supervision program.

All patients are classified into one of three groups: active, semiactive and sedentary. To conform with this plan, all activities have likewise been classified into three groups. The daily schedule at the camp has been planned to provide a maximum of optional activity, depending upon the patient's physical condition and classification.

Medical supervision begins on admission. All cardiac, chest and surgical cases are scheduled for early examinations. All other cases are seen some time during the first week. At the time of examination, the patient is advised as to physical activities permitted. Surgical wounds are dressed daily and are closely examined for evidence of healing, infection or herniation. Patients requiring surgical dressings have recuperated rapidly. The chief nurse assists in all examinations and treatments. Routine rounds are made daily throughout the camp by the physician in charge and by the nurse. In an acute emergency we have at our disposal the service of an ambulance for transferring patients to Metropolitan Hospital, which is located near by.

Such treatments are given as are possible with our limited medical facilities. Patients are permitted absences for clinic attendance when it is imperative. Otherwise, we prefer to have them spend a full day at the camp. Contacts are made with the out-patient department and, if it is deemed advisable, clinic appointments are temporarily suspended. It is here that the physician at the camp and the physician at the hospital maintain a partnership that is utilized to the best advantage of the patient.

We have found it a great advantage to have a medical social worker on the grounds at all times. Case work is done on a cooperative basis with the hospital doctor and social worker. Problems of a social or economic nature can easily be expedited with this arrangement.

The dietitian has been a great

asset in the camp administration. Adequately controlled diet has proved to be an item of fundamental importance in promoting the recovery of convalescent patients. Diets are colorful and inviting and supply full vitamin and caloric needs. Besides a hearty lunch of soup, fresh salad, meat, fish or fowl, vegetables, dessert and choice of beverages, extra nourishment is given to all patients in the middle of the morning and in the afternoon.

Occupational therapy as a prescribed treatment not only gives necessary exercise for mind and body

Occupational therapy serves two purposes: to amuse and to rehabilitate patients.

but prevents restlessness and overactivity and dissipates the tendency toward hypochondriacal ideas. Arts and crafts and recreational activities are adapted to develop strength in certain muscles weakened from disuse and to assist in increasing motion in joints stiffened from disuse or injury.

Occupational therapy is administered by a trained occupational therapist since overactivity or ill-advised work may do more harm than good. Play exercise is given high rank among the curative agencies. We have been rather fortunate in obtaining recreational workers, through the facilities of the W.P.A., who have done fine work in keeping patients entertained without overtaxing their physical and mental capacities. Their work is under the close supervision of the physician and other administrative officers who come in contact with the patients.

Any attempt to evaluate critically the possibilities of the convalescent day camp would be premature at this early stage. We have but opened the door. Intensive exploration remains to be made.

Since July 10, 388 patients have been afforded this extension of medical care, 208, or 53.6 per cent, of whom were referred from municipal hospitals and 180, or 46.4 per cent, from voluntary hospitals. These figures tend to impress one with the fact that there is undoubtedly a relatively equal need for this modified form of convalescent care existing in both voluntary and municipal institutions. Of the 388 admissions, 47.7 per cent were males and 52.3 per cent were females.

In reviewing admissions by diagnosis, it has been found necessary to differentiate between truly convalescent cases and chronic disease cases. The problem of chronic illness must be clearly distinguished from that of convalescence. The convalescent patient in the broad sense of the term is one who is in the process of restoration, rehabilitation and revitalization and, if institutional care is needed, the period of stay is comparatively short, usually three weeks. We have found it necessary to keep the patient over a longer period of time, the average being four or five weeks. A certain percentage of our cases could be put in the semichronic class and would require a much longer stay than the average person recovering from acute illness.

There have been 71 actual camp days. An average daily census of 94 patients was maintained with an average daily absence of 11. The largest number of patients in attendance, 156, was recorded on August 16. The smallest number, 60, was recorded on September 13.

One of our chief problems has been that of educating social service workers and physicians as to the aims of the camp. The initiative for referral of cases should be assumed by the members of the medical staff in each hospital; it is they who assume responsibility for the care and treatment of the patient and who are responsible in a great measure for outlining and instituting the program for the after-care. The details involved in the allocation and the transfer of patients to suitable convalescent homes can be delegated to the social service worker, but she should not be expected to bear the entire burden of the after-care of the patient.

The advantages of a day camp for convalescents are as follows: a relatively low cost; supervised and adequate diet; supervised recreational and occupational therapy; no discrimination on grounds of sex or color; continuity of home relationship, and superiority of facilities over home convalescence.

The disadvantages are: a break in the continuity of treatment; supervision and discipline of patients because of the day basis of functioning and exclusion of Sunday, and the difficulties of transportation, particularly for patients living elsewhere than in the immediate vicinity of the camp.

In a final analysis the value of the convalescent day camp as a service to the community rests with the referring agencies. The camp has a real service to perform if it is intelligently utilized in filling gaps that have long been reported in the field of convalescent care.

The Administrator's

GERHARD HARTMAN

WITH the increasing complexity of hospital administration and the entrance of many new specialized activities into the hospital, the administrator needs to understand more subjects. No longer can any one man profess to know all the answers. To arrive at intelligent decisions, the administrator should, therefore, have a ready source of reference or guidance to the latest printed material.

The administrator's primary responsibility is to interpret facts and to integrate them into the work of his hospital. No administrator can afford to be without a personal library in hospital administration.

As hospital administration achieves professional status, the bound literature will increase. Bound literature, however, is founded upon the studies and independent monographs that are undertaken by individuals or study groups. Bound volumes should serve as a foundation that is complemented by the material collected in file form. Both should help to open the doors to the allied fields of business organization and management, personnel management, medical staff organization, public relations, legal aspects of hospital administration, hospital architecture and construction and similar areas of knowledge.

In any issue of a hospital magazine one or more articles will be of particular interest to an administrator. When clipped and filed in such a way that they can be obtained in a few moments, these articles will help in guiding the administrator in his daily judgments as well as in planning his long-term hospital program.

The best material in the hospital field is scattered in the magazines, in the transactions and proceedings of national and state associations and in individual papers and leaflets. In addition, important material is to be derived from the studies of governmental groups, such as the Congress, the U. S. Public Health Service, the Department of Agriculture and other agencies.

The primary advantages of a personal library prepared on a subject index basis are as follows:

1. Articles are grouped according to subject matter.
2. A critical selection can be made from the entire bulk of the literature.
3. Extraneous material and those articles that have no particular interest or appeal can be discarded.
4. The administrator's critical faculties in appraising articles are developed.
5. Readers are stimulated to prepare original articles for publication.

Subject Index of Material for

- Accounting
  - Auditing
  - Budgets
  - Costs
  - Endowments
  - Rates
  - Statistics
- Administration (General Aspects)
- Admission and Discharge of Patients
- Ambulance Service
- Anesthesia
- Annual Reports
- Autopsies
- Blood Transfusions
- Buildings
  - Construction
  - Maintenance
  - Modernization
  - Planning
- Chronic Disease Care
- Collection of Hospital Accounts
- Community Chests
- Constitution and By-Laws
- Convalescent Care
- Cost of Medical Care
- Dental Service
- Dietary Department
  - Adminsistration
  - Instruction
  - Purchasing and Equipment
  - Therapy
- Educational Functions of the Hospital
- Emergency Service
- Equipment and Apparatus
- Ethics
- Eye, Ear, Nose and Throat
- Financing
  - Capital
  - Operating
- Fire Protection
- Forms, Miscellaneous
- Fracture Service
- Furniture and Fixtures
- Health Insurance
- History of Hospitals
- Housekeeping
  - Equipment and Purchasing
  - Instruction of Employes
  - Organization and Administration
  - Schedules for Routine Work
  - Supplies
- Incorporation of Hospitals
- Industrial Welfare
- Information Service
- Insurance
  - Coverage
  - Requirements
- Interns
  - Intern Education in Hospitals
  - Intern Records
  - Rules and Regulations for Interns
- Isolation
  - Construction
  - Hospital Care of Contagious Diseases
  - Isolation Technic
  - Isolation Wards in General Hospitals
- Laboratories
  - Charges for Service
  - Cost of Operating
  - Functions, Efficiency and Institutional Relationships
  - Location, Construction and Equipment
- Laundries
  - Cost of Operating
  - Description, Construction and Equipment
  - Guides for Standard Practices
  - Methods, Compounds and Formulas
  - Organization and Administration
- Legal Aspects
- Libraries
- Linens and Linen Control
  - Care and Distribution
  - Linen Rooms
  - Purchasing
  - Standards
- Manuals of Procedures
- Maternity Service
- Mechanical Plant
- Medical Records
  - Analysis of Institutional Activities
  - Case Records and Their Use
  - Chart Holders
  - Forms
  - History Taking
  - Hospital Record Rooms
  - Ownership of and Access to Patients' Records
  - Records, Unit History and Follow-Up

Professional Library

Executive Secretary
American College of Hospital Administrators

6. Administrators acquire a general appreciation over a period of time of the value of hospital literature in relation to current problems and developments in the hospital field.

The accompanying hospital library index is intended to be suggestive only. It is a condensation of my personal library file and has been used during the last two years by the graduate students at the University of Chicago. During the present year this list is also being used by the new group of more than 30 administrators and administrative assistants who are enrolled in the evening course in hospital administration at the University of Chicago.

The administrators of hospitals can easily instruct their secretaries to type subjects from the suggested list on filing folder tabs and thus organize the necessary equipment for systematically collecting materials.

A reading of the list may remind the administrator of subjects of current importance to him that he may obtain and insert in the file immediately. The list may be incomplete for the needs of some administrators and further subjects of particular interest can be added. If it is desirable, certain items can be expanded in order to subdivide material more extensively. The extent to which a hospital administrator will wish to collect materials is conditioned in part upon the quality of the hospital library in his own institution as well as upon the proximity of other sources and the availability of a hospital council for advice and guidance. It is also governed to a certain extent by his seriousness of purpose.

As administrators visit other institutions and attend hospital meetings and institutes, they collect forms for various purposes that may be adaptable in part to their own institutions. The filing of these forms has always been a problem. In most cases they are laid aside. With the aid of a filing system, the forms may be separated into their proper divisions and thus be available for reference when needed.

Hospital administrators are becoming increasingly desirous of preparing worth-while articles for publication. Instead of having the bulk of quality literature prepared by a few administrators, a growing tendency exists for others to send their offerings to the hospital journals. A collection of previously published material will serve as a ready source or guide in the preparation of papers and manuscripts for publication in current journals, which will help the administrator to avoid duplicating material already published and

Administrator's Personal Library

- Medical Staff Organization and Relationships
- Medical Schools
- Medicine, Internal
- Mental Hygiene
- Metabolic Service
- Nursing Education
  - Buildings and Equipment
  - Catalogs
  - Cost
  - Education for Staff and General Duty Nurses
  - Entrance Requirements and Credits
  - Examinations—School and State Board
  - Postgraduate Courses
  - Records
  - Relationships: hospital; out-patient department; university
  - Standardization of Methods and Courses
  - Teaching Methods and Technics
- Nursing Service
  - Biography of Leaders
  - Cost of Graduate *v.* Student Nurse Service
  - Duties and Responsibilities
  - Health and Personal Welfare
  - History of Nursing
  - Nursing Procedures
  - Organizations: professional; registry
  - Ratio of Nurses to Patients
  - Special Duty Nurses
  - Specialization of Nursing: anesthesia; mental; operating room; public health; surgical
  - Standardization of Nursing Technics
  - Supervision and Control
- Occupational Therapy
- Operating Rooms
- Out-Patient Department
  - Abuse
  - Admission and Appointment Systems
  - Construction and Equipment
  - Correlation With Hospital
  - Cost
  - Economic Status of Patients
  - Educational Opportunities
  - Follow-Up Systems
  - Organization, Functions, Administration
  - Personnel
  - Records
  - Supplies and Drugs
- Pathology Service
- Pediatrics
- Personnel Management
- Pharmacy
- Physical Examinations
- Physical Therapy
- Public Health
  - Communicable Diseases
  - Community Nursing
  - Current Problems
  - Midwifery
  - Nervous and Mental Diseases
  - Nutrition
  - Organization and Administration
  - Public Health Nursing
  - Records and Statistics
  - Tuberculosis
  - Venereal Diseases
- Public Relations
- Purchasing
- Receiving and Stores Management
- Research Studies (Administrative)
- Safety Programs
- Sites and Grounds
- Social Service
  - Functions of Medical Social Service
  - History and Development
  - Technic of Medical Social Service
- Social Workers
  - Duties, Responsibilities and Relationships
  - Education
  - Volunteer Workers
- Staff
- Storerooms
- Surgery
- Surveys
  - Community
  - Institutional
- Trustees
- Visitors and Visiting
- Women's Auxiliaries
- Workmen's Compensation
- X-ray
  - Charges for Service
  - Cost of Operating
  - Functions, Efficiency and Institutional Relationships
  - Location, Construction, Description and Equipment

to select subjects that merit further attention.

Editors of hospital journals are eager to hear from new contributors. When they select articles for publication they attempt to find those that are most significant to the largest number of hospital people. They consider the quality of the manuscript, its length, the point of view expressed, the illustrations available, the newness and value of the contribution and similar criteria. Each administrator must decide for himself, however, whether the article that is published contains facts and opinions that are useful to him in his present situation or in his general program of intellectual self-development and whether it offers new and constructive facts or viewpoints of value to the field.

Music for Mental Patients

MARTHA A. KALMS

MUSIC has a definite place in hospitals that are devoted to treating mental and nervous diseases, not only because it is one more link in the chain of therapies employed but because of its universal appeal. Few people, sick or well, fail to respond in some way to this most universal of languages.

The underlying purpose of all treatment of mental and nervous patients is to arouse their interest and emotions and to enable the individual to control and handle these emotions. It would be difficult to find a better medium than music for accomplishing this purpose.

Unison singing, for example, is an activity in which almost anyone can take part, if the group is large enough, without feeling self-conscious. It is an excellent way to release pent-up emotions in one patient, to stir up sluggish reactions in another.

By stimulating both circulation and respiration, singing increases the sense of physical well-being, which may react beneficially on the mental state. It helps to induce a more cheerful and hopeful mood on the part of a patient and to give a normal emotional outlet under conditions that, at best, are far from normal.

Another aim of musical therapy is to draw out any dormant or latent ability that a patient may possess and to develop this ability to such a point that upon discharge from the hospital the patient has a constructive hobby and knows how to use it to his advantage.

To gain this end the patient must participate actively in the musical program of the hospital since no amount of mere passive listening can help him develop his own potentialities. For certain patients music is the first activity in which interest is shown, and usually when a patient's interest and cooperation are aroused in one activity cooperation in the other activities of the institution follows.

From personal experience one teacher learned that when she had the "blues" the best way to overcome them was to play slow music and music preferably in minor keys. Gay music seemed an affront. But the most important part of the discovery was that after a period of playing so-called sad music, she drifted into gayer, lighter compositions and, as a result, felt much more cheerful.

Believing that, fundamentally, most people react to given situations in much the same way, this personal experience was put to good use in dealing with patients, individually and in groups. When a ward group seemed depressed at the beginning of a song period, the program would start usually with a lullaby. From that it would gradually be worked up to more dynamic songs. When a group was in a highly excitable state the process was reversed and the song period was begun with vigorous songs and ended with quiet numbers.

Since the aim of the music work in a hospital is primarily therapeutic, it is a mistake to present the subject too technically. With individual patients it is often necessary to go quite deeply into the technical side of music, but with the average group or individual anything beyond the most elementary technic is boring and when a patient is bored by an activity its therapeutic value is lost. Music must be enjoyed to have therapeutic value. It is much better to teach a song by rote and to have the patient enjoy learning it than to insist on having the patient acquire the technic necessary to get the song independently. The latter course only tends to produce dislike for music.

Teaching Must Be Systematic

The musical program in a hospital for mental and nervous diseases should be as systematic as in a school of music. It must be run on schedule if time is to be used to best advantage. The day should be divided into thirty and forty minute periods for individual voice and piano lessons and for community sings on the various wards. Each pupil should receive two lessons a week except when the demand for lessons is so great that new pupils must be started with only one a week because of an overcrowded schedule.

When conditions permit, there should be a glee club to take up one or two evenings a week. Dances should be held at least twice a month and both afternoon and evening programs should be given as often as the patients' talent permits. No patient, however, should ever be forced to participate in a program against his will since coercion may have a deleterious effect.

There should be no extra charge for music lessons in a hospital, for the musical therapist should not be handicapped in selecting patients for special lessons. The only basis for the selection of pupils should be one of need on the part of the patient, irrespective of the ability to pay. Not all patients would benefit equally from individual instruction.

Miss Kalms is director of music therapy, department of mental and nervous diseases, Pennsylvania Hospital, Philadelphia.

Contrast Media in X-Ray Studies

MAXIMILIAN JOHN HUBENY, M.D.

CERTAIN structures lend themselves to satisfactory x-ray study as a result of their natural contrasts; among these are bones; excavations of bones, which produce the nasal accessory sinuses and mastoid cells, and the thoracic cage. However, the perfection of apparatus, coupled with the response of chemists to medical minds in search of media for contrast methods of roentgenological exploration, has enlarged the scope of diagnostic roentgen procedures.

In the selection of any medium it is necessary to consider the degree of toxicity, ease of administration, dangers, contra-indications and limitations.

Methods in Use

The contrast media are of two kinds: one of greater opacity than the surrounding structures and the other of lesser opacity. In both instances the containing structures, organs or systems are not actually visualized but are seen indirectly by virtue of their contents, the latter being introduced by oral administration or some method of injection.

Some methods are limited to observations confined to variations in contour; others have physiologic values as well.

Solutions of colloidol thorium dioxide as opaque media have admirable density but it is the prevailing idea that they are harmful because they contain 25 per cent by volume of thorium dioxide. This tends to become fixed in the spleen, liver and lymphatic glands for long periods of time and is radio-active. Whenever it is used, therefore, it should be removed or used in conditions that permit its draining, such as visualization of sinus tracts, milk ducts and seminal vesicles.

Suitable iodized oils are employed for visualization of the nasal accessory sinuses, the bronchial tree, the uterine cavity and tubes, sinus tracts, milk ducts, seminal vesicles, urethra and spinal cord pathology.

The halogens, bromine or iodine, are also widely used in watery solutions for gallbladder, for renal, ureteral and urinary bladder investigations, for assistance in the determination of placenta praevia and, occasionally, for vasography.

Barium sulphate, which is usually suspended in a watery solution for examination of the alimentary tract, concludes the various opaque substances mentioned in this dissertation.

Gases, principally air, are used as contrast media for ventriculography, encephalography, pneumoperitoneal and perirenal insufflation, occasionally for myelography and sometimes for pulmonary and pericardial studies.

Opinions concerning the value of some of the applications of contrast media vary and unbounded enthusiasm and inadvisable usage are to be deplored. It is an axiom in medicine that it is not only desirable to know how to do a thing but also equally important to know when not to do it.

The following paragraphs will deal with some of the methods with more or less detail, giving emphasis to those having a frequent or important application.

Vasography.—The functional condition of a vessel and the tissue supplied by it depends mainly upon the size of vessel lumen. This can be studied within certain limits and has been of service in localization of emboli and thrombi; in the study of the site of vascular occlusion and of collateral circulation to determine the level of a necessary amputation; in the demonstration of vascular aneurysm of traumatic, arteriosclerotic or congenital etiology; in differentiation between spastic and organic vascular disease; in the study of the extension of varicosities, and in the study of the vascular supply in tumors and inflammatory diseases. Thrombo-angiitis obliterans, aneurysm of the popliteal artery, arthritis, scleroderma and Raynaud's disease are some of the conditions in which vasography may be of value.

Myelography.—Pain resulting from some pathologic involvement of the spinal cord or the spinal canal is sometimes hard to explain. This is especially true in low back pain, which is of frequent incidence; until recent years it has been too often ascribed to extraspinal causes, such as the sacro-iliac joints, postural deformities, fascial bands, taut pyriformis muscles and the vertebral articular facets. Intraspinal lesions, if considered at all, were listed near the end of the differential diagnosis. The steadily increasing number of reported cases of low intraspinal lesions causing low back pain, particularly herniated nuclei pulposi and hypertrophied ligamenta flava, prompts the suggestion that these lesions are far more common than generally supposed.

Progress in Spinal Studies

Accurate localization of tumors in the lower lumbar neural canal from clinical findings alone has been and probably will continue to be a difficult problem, owing to anatomic peculiarities of the region. However, much progress has been made by accurate roentgenologic studies after injection into the subarachnoid space of a contrast medium for visualization.

A suitable iodized oil or air has been used successfully. While air produces less irritative effects and is completely absorbed, from the standpoint of diagnosis of other than gross lesions, iodized oil is much superior. Iodized oil causes a local reaction in the meninges, the degree of which is largely dependent upon the presence of free iodine in the compound. When exposed to the air it liberates free iodine; therefore, it must have

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the minimal contact with air and should be in ampules. From 2 to 5 cc. should be injected into the subarachnoid space and studied on the fluoroscopic table, tilting the table from time to time to note the transit, impediments and irregularities.

This examination should not be performed until the patient has had a thorough general examination, neurologic study and previous x-ray investigation of the area suspected.

The question arises as to what happens to iodized oil left in the spinal canal in those cases in which the fluoroscopic examination reveals no lesion and in which laminectomy with removal of the iodized oil is not carried out. J. A. Sicard and J. Forestier reported that 2 cc. of iodized oil was eliminated from the subarachnoid space in about three years; a longer period was required if the oil remained freely movable.

Oil Has No Ill Effect

It can be demonstrated radiographically that iodized oil left in the subarachnoid space tends to be transported slowly out along the nerve sheaths from the spinal canal in those cases in which descent of the oil into the lower portion of the dural sac is possible; apparently no untoward results can be attributed to this. It is unwise to perform this procedure in the presence of an inflammatory lesion.

Alimentary Tract.—The usages of opaque media are well established and consist of the oral administration of barium and the injection of an opaque enema. The former makes possible the recognition of physiologic as well as pathologic processes and is used to recognize ulceration, neoplasms, obstructions and inflammatory conditions. The latter medium is especially useful in neoplasms, adhesions and redundancies. The method includes both fluoroscopic and radiographic types of examination.

I wish to emphasize the simplicity of determining the presence of a chronic appendiceal involvement after oral administration of a meal. The important finding is the constant elicitation of pain on pressure over the appendiceal region, even though the appendix may not be visualized; usually it is not seen.

Cholangiography. — This is a method of injecting an opaque medium, such as an iodized oil or a solution of colloidal thorium dioxide, through a tube after cholecystectomy to determine the presence of an obstruction in the common duct, usually resulting from a stone. It occasionally happens that at the time of the initial operation it is impossible to palpate or detect a stone with subsequent complications of obstruction.

Gallbadder. — Visualization may be accomplished by the intravenous injection or oral administration of a dye, utilizing a halogenated phenolphthalein. Both methods have certain advantages; however, the oral method is more frequently employed. While, like most diagnostic procedures, it has certain limitations, it has narrowed down the sources of error.

The following observations are of interest: the size, shape and position of the gallbladder; its regularity of outline; its power to concentrate the dye, and its ability to empty. In addition, variations in density within the gallbladder outline are of significance. This examination has two noteworthy purposes: (1) to see if cholesterol stones are present, which show in an indirect manner, and (2) to note the concentrating power of the gallbladder.

If soft stones are present and even if only a small amount of dye enters the gallbladder, the stones will be manifest in about 97 per cent of the cases. If a good visualization is present it can be interpreted as normal with an accuracy of 84 per cent. If no visualization occurs it denotes a pathologic gallbladder and is reliable to the extent of 80 per cent.

Urinary Tract. — Visualization is accomplished by two methods: intravenous or retrograde. Frequently one is followed by the other. When the opaque material is administered intravenously, the degree of visualization is dependent upon the kidney function, which, if impaired, may give little or no visualization. A high blood urea nitrogen or evidence of poor function obtained by other functional tests is a contraindication to intravenous injection.

Occasionally, for some unexplainable reason, a kidney may not show signs of excretion the first time and at a subsequent examination may become satisfactorily visualized. The ureters, as well as the bladder, usually fill quite satisfactorily. Again a radiopaque halogen is used, which is highly water soluble, thereby being rapidly absorbed and excreted. This method requires taking a series of films at certain time intervals.

The retrograde method demands a cautious injection of an opaque material, usually 12 per cent of sodium iodide for investigation of the kidneys and ureters and 6 per cent for studies of the bladder. This method should not be used in lower infections and it is unwise to inject both kidneys at the same time.

In some instances the urinary bladder is examined after air inflation.

Valuable Aids in Diagnosis

These methods are valuable acquisitions and assist in the recognition of normal anatomy, congenital anomalies, physiologic variations, upper urinary infections, lithiasis, obstructive lesions, tuberculosis, tumors, traumatic lesions, postoperative states, lesions of the bladder, placenta praevia and similar conditions.

Pneumoperitoneum. — The injection of air into the peritoneal cavity is done only occasionally now as compared to a short period of popularity about twenty years ago. About 2 to 4 liters of air are injected and observations, both fluoroscopic and radiographic, are made from various angles and positions, using the tilt table to get the effect of gravity. In this way pelvic and abdominal studies can be made to note the size, shape and position of the liver, spleen, uterus, ovaries, tumors, infiltrations, adhesions; also thickened peritoneum resulting from tuberculosis or carcinomatosis may be demonstrated.

The only orifice that has been untouched is the eustachian tube. Also, chemists may discover some innocuous material to promote intensive study of the vascular and reticulo-endothelial systems.

Air Injections.—Air as a contrast medium is especially useful in ventriculography and encephalography. By replacing a sufficient amount of withdrawn spinal fluid with air injected into the subarachnoid space, the anatomy of the normal or ab-

normal pathways of the cerebrospinal fluid is revealed. Lesions, direct or indirect, of the ventricular system are often found by this method. Encephalography is contraindicated in cases in which there is increased intracranial pressure or a cerebellar tumor.

Uterotubography.—A suitable iodized oil is used to visualize the uterine canal and tubal passages. It should not be used in acute or subacute infections, in marked hemorrhages, pregnancy and fever or in severe pulmonary or cardiovascular diseases. It is especially useful to determine the patency of the fallopian tubes, in menorrhagia, metrorrhagia and certain intrinsic and extrinsic tumors.

Bronchography.—The injection of an iodized oil into the bronchial trees is of value in the recognition of bronchiectasis, fibrotic dried up abscesses and neoplasms. This procedure is never indicated in any acute infection, including tuberculosis. It is especially contraindicated in myocardial diseases, extensive emphysema or fibrosis and acute or subacute inflammations. It should be used with care in patients with asthma.

There are several methods of instillation: (1) the oral or supraglottic route; (2) the transtracheal route, and (3) the bronchoscopic route. After injection, drainage may be accomplished by posturing the patient in the prone position with head and chest at a lower level. Also, a patient should be instructed not to swallow the opaque material for, should an iodine compound be used, iodism might result. In addition, a brisk cathartic may be given.

Mammography.—By injecting a solution of colloidal thorium dioxide into small estuaries of the nipple or directly into the tumor, N. F. Hicken was able to recognize the presence of papillomas, simple cysts, cystic degeneration of the breasts, galactoceles and carcinomas. This procedure should not be done in the presence of an acute infection, and the injected material should be removed from the tumor by massage or suction.

Another View of Intern Service

CHARLES L. CLAY, M.D.

IN HIS article, "Who Sells Interns' Services?" in the November issue of The Modern Hospital, Dr. George F. Stephens sounds a warning against staff members unwittingly making a charge to private patients for services actually rendered them by interns. The plan of providing intern service to assist the attending physicians is acceptable on public wards, he states, but apparently he frowns upon any contact between the intern staff and private patients.

My own observations have led me to a different point of view, namely, that the services of interns, especially of residents and assistant residents, may be used for private patients legitimately and even advantageously, and the patient, doctor and intern all share the advantages.

Doctor Clay is medical director of the Long Island Hospital, Boston.

First, patients who are used for teaching purposes usually benefit from the critical scrutiny to which the attending physician's diagnoses and therapeutic measures are subjected by his pupils. Next, there is the instruction value to the intern. Every physician has seen rare and interesting developments occur in the conditions of private patients. As to the general run of cases, there are hospitals in which the number of public ward patients is so limited that it seems almost obligatory for the hospital to supplement them by observation of private cases if it is in any way possible.

Pathologists and roentgenologists seldom have scruples against using private patients as teaching material for their pupils; it is the clinician who hesitates, probably because he fears that his patients may object. Yet there is ample experience to show that if he makes the introduction in the right way the patients are pleased rather than offended at the attention. Rounds and work-ups in the private ward also furnish the intern with instruction in the manner of handling these patients, who as a group are somewhat different from public ward patients in their attitude and requirements.

There is also what may be called the teaching value to the physician. Some private patient may give the intern just the right opportunity for introducing the attending physician to a new and useful diagnostic or therapeutic technic that he has learned in medical school or in some other hospital. This possibility is by no means restricted to small hospitals or to those that are remote from centers of research.

The considerations already mentioned apply to surgical as well as to medical cases but in surgical cases there is the additional problem of operating assistants. Doctor Stephens' attitude against an intern's being used as a substitute for an assistant who would receive a fee is correct, but the intern could stand by the table as a third man, holding retractors or doing other useful things for which no second assistant would be employed anyway. In some hospitals the intern will be a member of the teaching surgeon's operating team, used for ward and private patients alike.

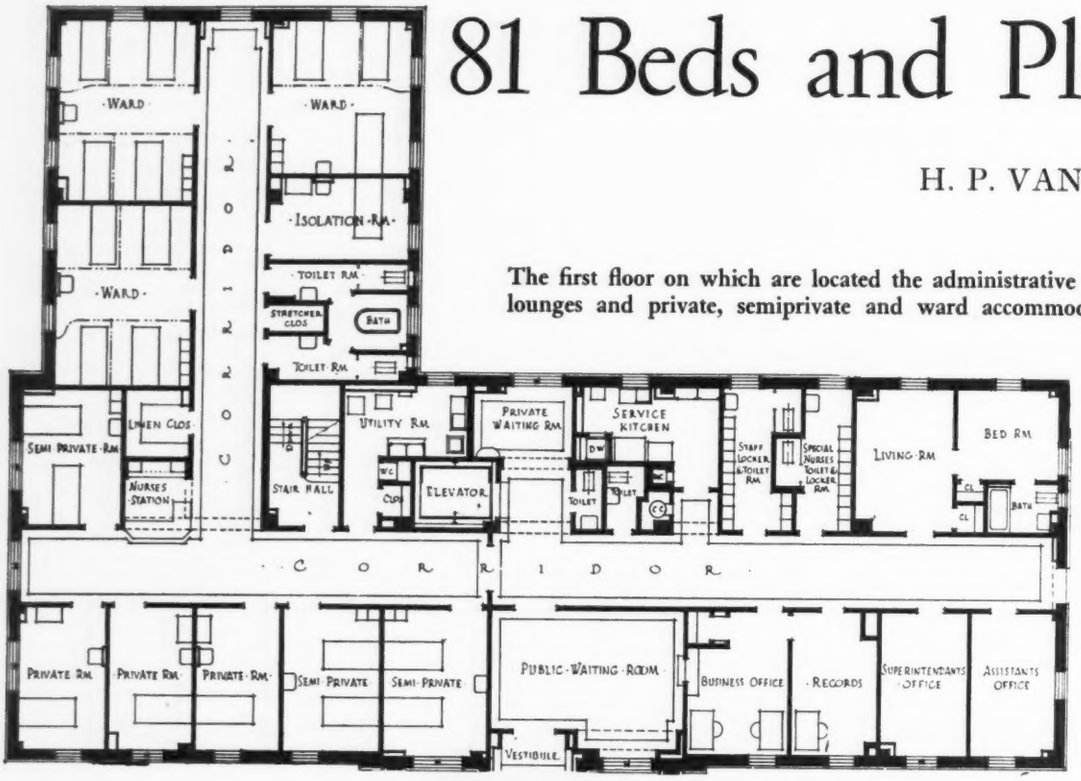
In addition to general benefits there are occasional specific benefits to individual private patients in the way of emergency treatment. When such measures are necessary and when the physician is either temporarily inaccessible or still on his way to the hospital, it is advantageous to call the house man who is familiar with the patient's malady. Furthermore, there is a psychological advantage to the patient, for he has confidence, developed through previous acquaintance, in the character and ability of the house man.

As Doctor Stephens has pointed out, however, all these services should be charged to teaching activity rather than to the patient's account, and it seems to be the responsibility of the administrator to see that this is clearly understood by the visiting staff and that the rule is obeyed.

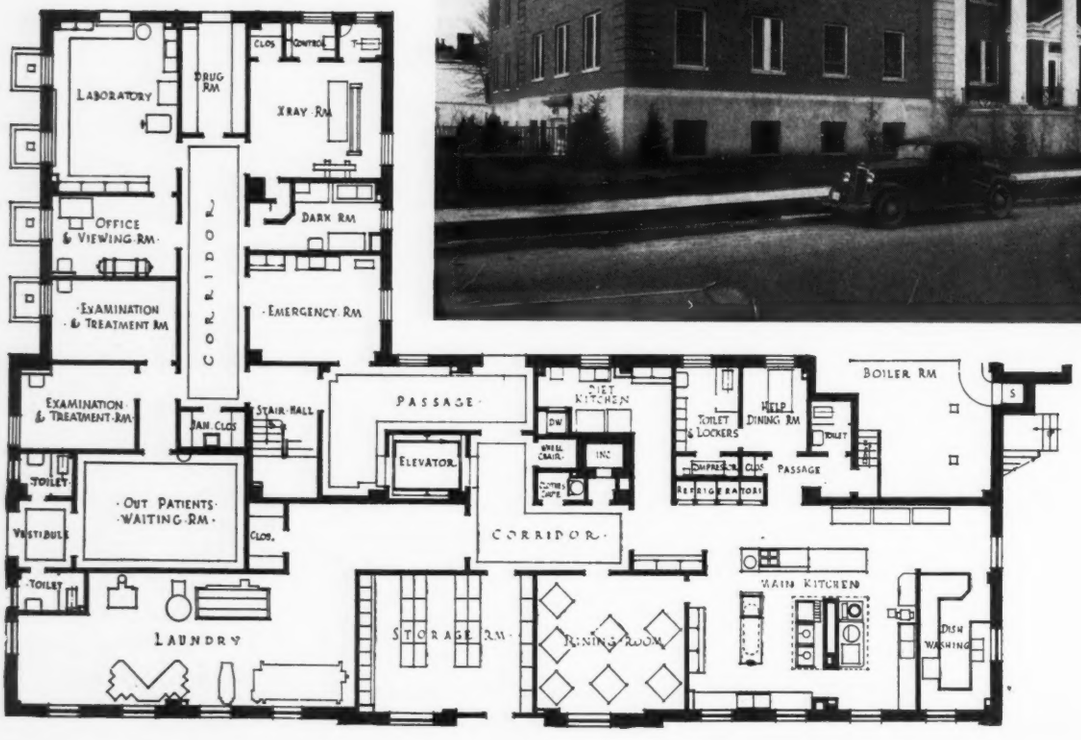
81 Beds and Plenty

H. P. VAN ARSDALL

The first floor on which are located the administrative offices, lounges and private, semiprivate and ward accommodations.



Right: Exterior view of the building designed by Samuel Hannaford and Sons, Cincinnati architects. Below: Floor plan of the basement showing the laboratory, x-ray department, out-patient department, kitchens and laundry.



# of Space Around Them

Architect, Samuel Hannaford and Sons, Cincinnati

THE newly constructed general hospital for the Silent Workers' Circle of the International Order of the King's Daughters and Sons, Inc., in Frankfort, Ky., represents the successful effort of this organization to provide modern and adequate facilities to care for the sick in Kentucky's capital and environs.

The new building of the King's Daughters' Hospital makes available approximately 81 patient beds and is situated on a level plot in the heart of a residential district within a few blocks of the capitol building, at the northeast corner of Third and Steele streets.

The development of the construction program was begun early in 1936 and carried forward to a successful conclusion in 1938. The building is four stories high, including the basement (or ground floor), and is of the skeleton type of reenforced concrete, with enclosing walls constructed of selected cherry red common brick to harmonize in character with the southern Colonial style of architecture so prevalent in this community. It measures 119 feet across the main elevation with a north L extension approximately 42 feet in length.

The general scheme of plan is neither unique nor startling, but it does indicate a proper sectional division, location and economical disposition of space to house the various departments according to their respective uses and accessibility.

The basement area includes the receiving and out-patient department, laundry, culinary department, boiler room and coal bunker.

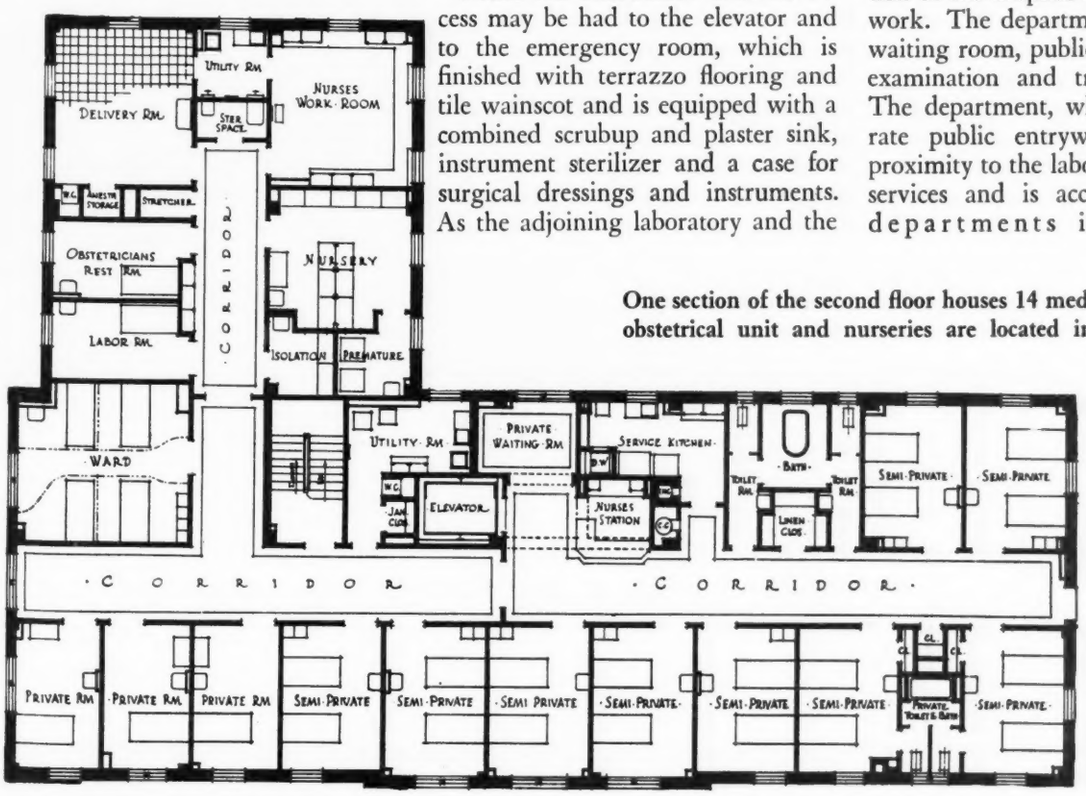
For incoming stretcher or semi-ambulatory cases, an entrance is provided at grade level in the rear of the building. There is an electric push button at the entrance that operates an audible signal in the elevator and at the first floor nurses' station to ensure patients immediate medical and surgical care. In the ambulance entrance corridor a space is provided for wheel chairs and stretcher.

From the ambulance corridor access may be had to the elevator and to the emergency room, which is finished with terrazzo flooring and tile wainscot and is equipped with a combined scrubup and plaster sink, instrument sterilizer and a case for surgical dressings and instruments. As the adjoining laboratory and the x-ray services are to be in charge of a single technician, the departments are planned accordingly.

The x-ray department is arranged with a combination office and film viewing room, radiographic room, film developing dark room and light lock, toilet and barium room, control room and storage closet. Walls and doors of the radiographic room are adequately insulated with sheet lead to protect other portions of the hospital from harmful rays. The control room door is provided with an observation "lead glass" panel; all windows are equipped with light lock shades and the doors, with light-tight threshold. The dark room has a refrigerated developing tank, utensil sink, vertical film dryer, film safe, lightproof and rayproof pass box, long work counter, storage cabinets and safe lights.

The laboratory adjoins the technician's office and is equipped with centrifuge, steam autoclave, acid resisting sinks, high and low work counters of acid resisting material, shelving, cases and cupboards.

Because few out-patients are served in this community, only a small section of the hospital is devoted to this work. The department consists of a waiting room, public toilets and two examination and treatment rooms. The department, which has a separate public entryway, is in close proximity to the laboratory and x-ray services and is accessible to other departments in the hospital.



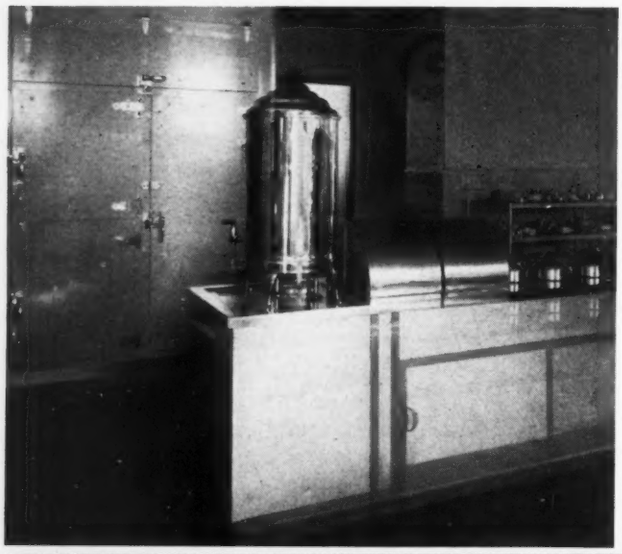
One section of the second floor houses 14 medical patients. The obstetrical unit and nurseries are located in the west wing.

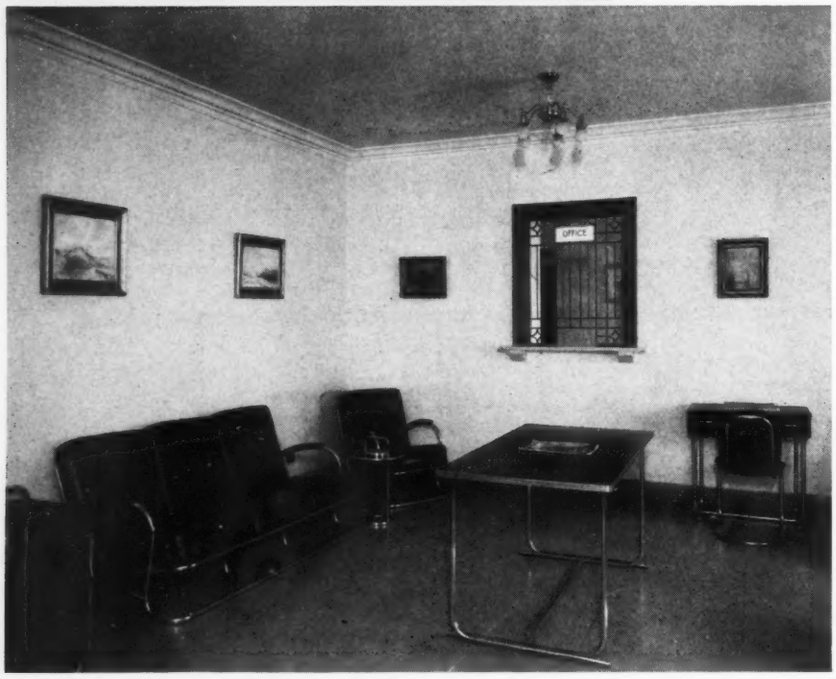
The laundry, isolated from other departments, is provided with a mechanical washer, soap tank, extractor, drying tumbler, flat work ironer, garment presses and ironing board.

The culinary department includes storage spaces for tubers, canned goods and cereals; dining rooms; diet kitchen; main kitchen (equipped for central service), and accessory spaces. The main kitchen is equipped with large gas ranges, soup kettle, mixer, steam table, peeler, coffee urns, warmer, electric dishwasher, large reach-in and walk-in refrigerators, exhaust hoods and sinks. Equipment is of the highest quality with table tops and service counters that are made of stainless metal.

The first floor is approximately seven feet above grade, which permits of a well-lighted basement, and is approached by a series of easy steps through the front portico. The east portion of the floor houses the administrative section and includes public and private waiting rooms, business office, record room, superintendent's and assistant's offices, utilities and the superintendent's living quarters. The remainder of the floor is given over to patient occupancy and nursing facilities.

Private rooms are approximately 9 feet 8 inches wide by 15 feet 6 inches long with 9 foot ceilings, allowing the patient 1360 cubic feet of air space. The floors are of terrazzo, with special terrazzo wall base back of beds to form a stop and to prevent plaster damage. All terrazzo and plaster angles and corners are rounded to facilitate cleaning. The lower sash of the double-hung windows are constructed with deep bottom rails for the purpose of avoiding drafts, permitting ventilation at the meeting rails without raising the bottom rail above the level of the window stool. Window stools are of polished Tennessee marble.





Left: A corner of the main kitchen, showing the huge walk-in refrigerator and part of the steam table. Below: The waiting room is equipped with modern tubular steel furniture.

Doors are of the flush slab type 3 feet 9 inches wide by 7 feet high and 1¾ inches thick. They are hung to flush metal frames and are equipped with the hospital type of hardware and with automatic closers.

The furnishings of each room consist of small washable scatter rugs, window draperies, bed, bedside table, dresser, chairs, fan, nurses' call system, outlet for portable radio, reading lamp over the head of the bed, outlet for examination lamp or electric hot pad, a vitreous china pedestal lavatory with elbow action valves and bell-spray and a plate glass shelf for storing the patient's medicines and thermometer.

Semiprivate rooms and wards are similar to private rooms, except that they are equipped with built-in clothes lockers. Wards are provided with cubicle curtains for patient isolation.

Utility rooms are isolated to prevent the transmission of noise to patients' quarters but are conveniently located for the nurses. These areas are equipped with every modern device to facilitate the work of the nurses and are finished with terrazzo floors and tile wainscots.

Corridors are of the customary 8 foot width, with elliptical ceilings, ceiling illumination and night floor lights, protective terrazzo projecting bases, terrazzo borders and asphalt tile floor centers.

The second floor is arranged in two sections. In the east portion are rooms for 14 medical patients; the rest of the floor houses 11 maternity patients, the nursery, nursery isolation and premature rooms, labor room, obstetricians' rest room, nurses' workroom, delivery room and nursing utilities.

Private and semiprivate rooms and wards on this floor are constructed

in much the same fashion as was employed on the first floor.

The isolated obstetrical section has its separate nurses' workroom and utility and sterilizing room, located conveniently close to the nursery and delivery room. The finish and appointments of the delivery room are modern in all particulars. The floor is of dark green terrazzo, equipped with a brass hospital grid for grounding static electric sparks; walls are wainscoted to a height of 5 feet with willow-green cushion edged tile, while the furnishings consist of a double scrubup sink, obstetrical lamp and numerous electric (nonsparking) outlets for portable lamps.

The unusual feature of this floor, however, is the nursery with its unique equipment for practicing aseptic technic. Here are provided low metal cases with individual supply drawers and cupboards underneath a stainless metal counter top, 36 inches high. Bassinets are separated by plate glass partitions, 18 inches high. Adjoining the nursery are similar areas for premature and sick infants.

The third floor is devoted entirely to surgical work and surgical patients and is occupied by two major operating rooms, nurses' workroom, sterilizing room, scrubup room, doctors' locker and toilet room, nurses' locker and toilet room, utilities and beds for 24 patients.

The major operating rooms are 18½ feet long by 15½ feet wide with 11 foot ceilings and are finished in the same manner as the delivery room. Each is equipped with a small built-in emergency supply surgical case, a warming closet, a surgical lamp suspended from the ceiling, cleanup illumination, nonsparking electric outlets for portable equipment, film viewing illuminator and lightproof window shades.

Exterior windows are of wood with double hung sliding sash and full opening metal insect screens. Interior partitions are of 4 inch plastered hollow tile. Shelving, cabinets, cases, blanket and warming closets are metal or wood, as the service demands; door frames are of the flush metal type, cut 6 inches short at the bottom to permit the continuation of the terrazzo base through the door opening to form a mop strip. Doors to stair halls and elevator are of enameled hollow metal, and all others are of flush wood of the veneered type and are equipped with hospital hardware.

Wainscots in operating and utility areas are of matt-glazed cushion edged tile. Floors, in general, are of terrazzo with wall bases of the same material; floor centers in the corridors are of asphalt tile.

The heating system is of the low pressure steam type, with automatic temperature regulation in all operating rooms. There are a general exhaust system for the kitchen, utility rooms, toilet rooms and other areas requiring ventilation and a conditioned air supply and exhaust system for all operating and delivery rooms. The electric wiring system includes power for all motors and x-ray units, lighting, emergency lighting, signals, clocks and telephones. Elevator and dumb-waiter are of the automatic electrically operated push-button type.

The bed capacity is allocated as follows: labor and isolation rooms, 2 beds; private rooms, 9 beds; semi-private rooms, 44 beds; three and four bed wards, 19 beds, and bassinets (figured at one-half bed each), 7 beds. The proportionate share of gross floor area for each patient is 325 square feet and the proportionate share of gross cubic contents for each patient is 4222 cubic feet.

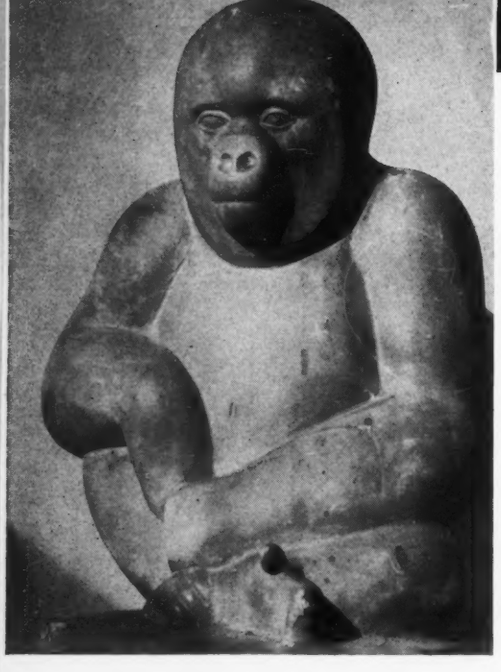
Table 1—Data on Occupancy of Hospital

Department	*Square Feet*	*Per Cent Total Floor Area*
Boiler room and cold storage	1116	4.2
Incinerator and clothes chute	164	0.6
Janitor's closets	90	0.3
General storage space	334	1.2
Elevator, dumb-waiter and stairs	949	3.6
O.-P. department, including drug storage, laboratory and x-ray department	2072	8.0
Emergency and receiving department	206	0.8
Administration department, including superintendent's quarters	1867	7.1
Public toilets	162	0.6
Culinary department, including dining rooms and grocery storage areas	2043	7.9
Laundry	840	3.2
Patients' and infants' rooms and wards	7635	28.9
Patients' services, including nurses' stations, charting spaces, baths and toilets, utility rooms and service kitchens	1461	5.5
Corridors and vestibules	5165	19.6
Solariums	180	0.7
Linen rooms and supply closets	207	0.8
Surgical and obstetrical departments	1845	7.0
Totals	26,336	100.0

Table 2—Data on Cost of Hospital

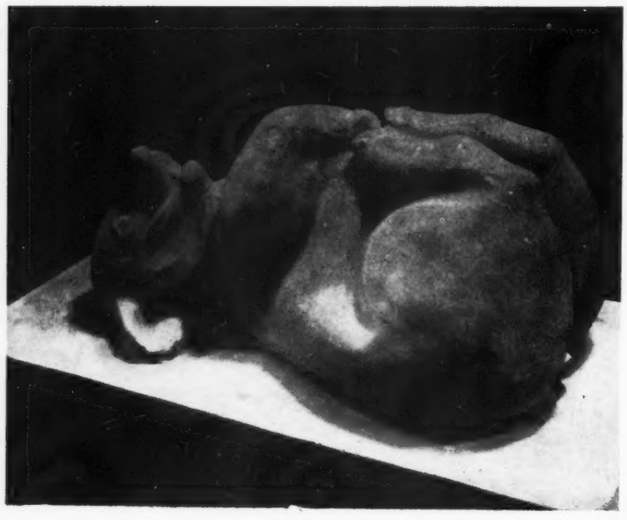
Equipment	*Contract Amount*	*Per Cent Total*
General contract, including driveways, walks, all built-in cases, cabinets and laboratory equipment	$116,981.00	54.04
Plumbing	23,444.00	10.83
Heating and ventilating	23,984.00	11.08
Electric work	9,894.00	4.58
Elevator	9,175.00	4.23
Sterilizers	6,382.00	2.94
Kitchen equipment	4,283.00	1.98
Clothes chute	430.00	0.20
Laundry machinery (estimated)	6,800.00	3.14
	$201,373.00	93.02
Architects' fee	15,102.00	6.98
*Total	$216,475.00	100.00

*Does not include cost of property, movable furniture, china, silverware, linens, bedding.
Cost complete per square foot, $8.22.
Cost complete per cubic foot, $0.63⅓.
Cost complete per patient bed, $2673.00.



CAST STONE ANIMALS

Installed on the children's outdoor playground at Biggs Memorial Hospital, Ithaca, N. Y. They were designed by the sculptors of the W.P.A. Federal Art Project.



Staff Problems of Small Hospitals

JOSEPH C. DOANE, M.D.

ONE of the most difficult problems that confronts hospital administrators and trustees is the organization and conduct of the medical staff. In the smaller communities, the difficulty is intensified by the fact that business, social and family relationships are inextricably tangled. Cliques that foment dissension and personal animosity between the staff and the administrator or among members of the staff can easily destroy the efficiency of the hospital. Too often such troubles arise because of weakness or indecision on the part of the board. An institution that is headed by a group of men and women who refuse to be stampeded by popular opinion is fortunate.

The first step that should be taken by a hospital that is experiencing staff difficulties is to adopt a clear, complete but not too complicated set of rules governing professional activities and relationships. Such rules should originate with the staff and should be submitted to the board for its approval.

The board of trustees should then be made to realize that it is legally, as well as morally, responsible for the action of its staff members. The truth of this is evidenced by the fact that in many states the courts hold hospitals responsible for injuries to patients as a result of carelessness or incompetence on the part of staff members. In a few states, such as Pennsylvania, an injured person cannot recover damages from a charitable institution. In others, however, the laws have been revised and judgments have been obtained against hospitals.

In hospitals of all sizes the appointment of the staff is often poorly planned and executed. For example, a board that considers itself under obligation to a prominent physician who has kept the hospital out of the red will not go through the formality of appointing and reappointing him. Good practice requires that the trustees send a formal letter of appointment to every member of the staff at the end of the year, informing each of his reappointment and setting forth the period during which he is to serve. Unless this is done, service on a hospital's staff will be cheapened and reappointment will be taken for granted.

Before annual appointments are made, the board's staff committee, the administrator or some other officer should check over the records of each man in regard to attendance at staff conferences, the number of cases referred to the institution and the number of scientific contributions made by each one during the last twelve months. Every member of the staff can and should read at least one paper a year before some medical society or group; should attend a majority of postmortem examinations held on patients that have died on his service, and should attend at least three fourths of all staff conferences held. Such attention on the part of the board to the details of staff activity serves as an incentive to increase the scientific work of the hospital.

Staff discipline can be best carried out by a subcommittee consisting of physicians. It is often wise, however, for this committee to be nominated by the staff and appointed by the board. Its duties and prerogatives vary widely from those of the general conference committee.

Appointments to major staff vacancies should be made by the board which may, if it chooses, seek the advice of the physicians. The trustees should, however, have a free hand in filling such vacancies without being restricted too closely by staff opinion. Each appointed physician should have full authority to select and organize his own staff, the approval of his nominations being more or less routine. Any semblance of high school discipline or heckling methods should be avoided. A display of such bad taste often arouses justifiable resentment in good staff members. Often, when difficulties and misunderstandings arise, the president of the board and the administrator acting together can adjust matters to the satisfaction of all, although charges of unethical practices should first be reviewed by the medical executive committee.

Whether a staff committee functions well will depend quite largely on the courage and strength of character of its members. If, in order to avoid unpleasantness, physicians equivocate and avoid making decisions, disaster is likely to follow.

In many instances, the difficulties that develop between the staff and the administrator arise because of ineffectualness or lack of diplomacy on the part of the administrator. The development of a deep rooted antagonism between the superintendent and the staff is often the result of a total lack of understanding as to the duties and the methods of each.

Practical Suggestions for Avoiding "Staff Trouble"

1. **Make formal appointments for prescribed periods of service.**
2. **Gradually develop staff specialization in hospitals that are not organized on such a basis.**
3. **Develop some setup for liaison between the staff and the board, such as a conference committee, an executive council or some similar arrangement.**
4. **Assure firm support of the administrator by the board of trustees as its representative.**
5. **Develop the understanding and support of the community so that the public, through its representatives on the board of trustees, will not permit the formation of cliques or allow any individual to profiteer at the expense of the hospital.**
6. **Settle disputes through conferences.**

There are too many administrators who are unable to choose the proper time and place to achieve the results they are seeking. The administrator should not exhibit too great haste in solving the staff problems that confront him, since haste often precipitates a personality crisis. Conferences and more conferences are often necessary to an amicable outcome.

To be sure, there are physicians and hospital executives who seem fundamentally unable to understand each other's motives. An example of such a person is the superintendent who served in a number of good hospitals for varying periods of time. In each instance, however, he failed because he lacked skill in handling the staff and treated its members like children or criminals. An otherwise good administrator was spoiled because of his personal animosity against anyone who possessed a medical degree.

A superintendent may be weak in his contact with the board and the staff, putting off unpleasant or unpopular decisions and thus piling up trouble for a future date. It is a good practice to decide each case as it comes to his attention.

One of the most valuable assets a hospital can possess is a courageous president of the medical staff. It is easier for him to perform his work if he is a man of financial and social independence.

Here and there, unfortunately, one finds a physician who will not obey hospital rules. Often a staff president can handle such a person more effectively than can either the board or the hospital superintendent. It is far better for such discipline to originate within the staff, thus building up the fact that it is popular to play the game according to the rules.

In a small hospital, staff trouble often arises because of a lack of cooperation between the physician and the administrator or between a staff member and a colleague. The history of hospital administration in this country during the last ten years contains frequent examples of the most devastating personal battles in small hospitals because of the uncontrolled ambition on the part of one or more men to obtain medical practice. Such activities frequently express themselves in some form of division of fees or in other types of unfair competition among physicians. The hospital board is responsible for preventing such activities and it can accomplish this by refusing to reappoint a man whose behavior during the past year has been unethical.

A strong, active board, not too large in number, with proper committee organization, can usually solve any difficulties before they become too serious. Whenever it is possible, a physician should act as a liaison officer between the board of trustees and the staff. Sometimes the staff elects a chief of surgery and a chief of medicine who serve with a third physician appointed by the board as an executive council. Such an arrangement is not a bad one if all recommendations pass from this council over the administrator's desk.

School for Employes

GRAHAM F. STEPHENS

COULD subjects be found that would interest hospital personnel? That was the question that faced the Evanston Hospital, Evanston, Ill., when a five week school for hospital personnel was first considered. Before a syllabus was arranged the principal objective of the training program was formulated, namely, to give employes a better understanding of the hospital and its organization and to ensure that each one was given adequate instructions for the best performance of his task. Nearly 1000 half hour units of instruction were provided.

The school program was divided into two parts. The first was a series of weekly half hour classes that extended over a period of three weeks, the same subject being repeated three times each week at different hours so that classes would coincide with work schedules, insofar as possible. For the second part of the course, each department met in departmental classes once each week for two or three weeks. Whenever possible, employes attended class on the hospital's time, although night shift employes were among the most faithful attendants. All employed personnel except graduate nurses participated. We hope to give the same instruction to the nurses at an early date.

The nurses' auditorium was used for general sessions and gave a formal atmosphere to these meetings. Later, small classrooms were used for departmental meetings. Attendance was taken and was compulsory and after the "scholars" discovered that classes would begin and end on time the number of latecomers decreased from 14.6 per cent to 0.4 per cent.

The subject matter for the general sessions was comprehensive and varied. The first lecture was concerned with the history, organization and purpose of the hospital and how it is financed. This lecture was given by the superintendent, who also explained the purpose of the training program. In the second lecture the assistant superintendent stressed the importance of hospital public relations and in a third lecture the administrative intern dealt with the question of work attitudes, correct dress and appearance. Among the subjects discussed in the departmental sessions were the function of the department, its relationships with other departments, economy, courtesy and departmental technics.

Comments by the hospital personnel on the training program were most favorable. One worker said that she had not realized that one could work so long in a place and know so little about it. Many said that they had gained a wider knowledge of how the hospital began and how it is financed; others were impressed with the complexity of interdepartmental relationships and the need for complete cooperation among departments. Department heads, too, came to realize the value of a training program in improving the work of their departments and they plan to repeat classes for their personnel at regular intervals. The administration is greatly pleased with the results achieved.

Mr. Stephens is assistant superintendent of the Evanston Hospital, Evanston, Ill.

Floor Accidents and the Law

EMANUEL HAYT

.....
Date

To Whom It May Concern:

This is to certify that I do not hold the Methodist Hospital responsible for the fall that occurred.....as the spot on which I fell was clean and dry and free of any defect, foreign substance or other condition that could be the cause of the accident.The accident was due solely to.....

.....

Signed: .....

Address: .....

Witness: .....

HOSPITAL maintenance men may use wax, oil or any other substance to polish a floor in the customary manner without incurring legal liability to one who slips and falls, unless the institution is negligent in the materials it uses or in the manner of applying them. If damages are to be recovered, something more must appear than that the floor has had such treatment as is customarily applied. The duty of the hospital is to exercise ordinary care for the safety of those who have occasion to walk on the floors and that duty is not violated by merely oiling or waxing and polishing a floor in the usual way, although the floor is thereby rendered slippery.[1]

The question of whether reasonable care had been displayed is usually determined by the jury, if the case is tried before a jury, and the decision is based on the facts and circumstances of the particular accident.

In one instance in which a person was injured by slipping on a highly polished linoleum floor and when the evidence showed that the surface of the floor had been installed in the customary manner; that it was cleaned regularly each week and waxed according to the recommendation of the manufacturer, the court held that the plaintiff had produced insufficient evidence to warrant having the jury pass on the issue of negligence and dismissed the complaint.[2] Questions of fact are within the province of the jury unless the undisputed facts do not constitute negligence on the part of the hospital as a matter of law.

Ordinarily, the hospital is not liable for accidents that are caused while the process of cleaning the floor is going on, since no better method has been devised by man for cleaning floors than the use of water and some soapy preparation.[3] However, if the floor is left in a wet and soapy condition by the porter and someone is injured by slipping, the hospital may be held liable.[4]

Washing and waxing a floor are not in and of themselves inherently dangerous, although in both operations parts of the floor are necessarily made temporarily wet and slippery during the actual process. To recover damages it must be shown by the visitor, not only that the hospital was negligent but that he himself did not by his own fault contribute to the happening.

In a lawsuit it is for the jury also to say whether the claimed slippery condition of the floor and the fact that it was then being oiled and waxed were so obvious and discernible that an ordinarily prudent and careful visitor would immediately have observed them and would have taken such care for his own safety as was commensurate with known conditions and so would have avoided the accident.

While a hospital is not an insurer of the safety of persons, it is, nevertheless, under a duty to exercise reasonable care to keep the floors of the lobbies and halls in a reasonably safe condition for access and egress to those who are lawfully on the premises and who are free from fault. When the floor directly in front of the elevators or adjacent thereto has been made slippery, oily and greasy so that the condition is not readily discernible to one stepping from the elevator and when it is not obvious that the worker has been oiling and waxing the floor, it is a question of fact whether some form of notice should not have been given to the public.[5]

From the standpoint of practicability and justice the court will look to the customary, generally recognized and commonly observed standards in any long established line as to what is adequate and proper, in preference to the notions of a particular jury, many of whose members have had no experience whatever in the observation of hospital floors. The rule of care applied to hospital floors is no different from that required of public buildings and other places frequented by the public.[6]

Although the law is well settled that the owner of a building, who by invitation, express or implied, induces another to go upon the premises, is liable for injuries occasioned by the

The author is a partner in the law firm of Hayt and Hayt, New York.

[1]Bonawitt *v.* Sisters of Charity of St. Vincent's Hospital, 43 Oh. App. 347.

[2]Daniel *v.* Jackson Infirmary, 173 Miss. 832.

[3]Samuels *v.* Terry, 227 App. Div. 68, aff'd. 253 N. Y. 593.

[4]Shearod *v.* 41 St. & Park Ave. Corp., 254 N. Y. 618.

[5]Eisenberg *v.* Irving Kemp, Inc., 11 N. Y. S. 2d 449.

[6]Daniel *v.* Jackson Infirmary, 173 Miss. 832.

unsafe condition of the floors of which he has knowledge, there is no liability for dangers that are obvious or well known to the person who is injured. It is only when the perilous condition is known to the hospital and not to the person injured that a recovery is permitted. There is certainly no presumption of negligence on the part of the hospital merely by showing that an injury had been sustained by one rightfully upon the premises.

A special duty nurse who was injured by a fall on a slippery corridor could not hold the hospital responsible, since it was shown that she had continued to use the corridors although she knew of their dangerous condition. She was held to be a nurse in the private employ of the patient; the hospital owed her only the duty to exercise reasonable care to keep the premises in a safe condition.[7]

Patients May Recover Damages

In these slippery floor cases, hospitals have been held answerable for damages to patients as well as to strangers. A visitor who had come to see a patient was injured on her way out of the hospital by slipping and falling on account of soapy water. At the trial the porter testified that he had mopped the floor with a solution of water and soap powder; that the linoleum covering was eight or ten years old and was torn in parts.

An expert on linoleum flooring who was called to give his opinion said that the condition of the linoleum, under such circumstances, was a competent producing cause for the slimy condition at the time of the accident. Damages were, therefore, awarded to the injured person by the court.[8]

In New York State, where hospitals are held liable for the negligent acts of a "mere servant or employe functioning in that character," a voluntary institution may be responsible even to a patient for injuries caused by reason of a slippery or defective floor.[9]

[7]Mantino *v.* Sutter Hospital Assn., 211 Cal. 556.

[8]Johnson *v.* Staten Island Hospital, Inc., 271 N. Y. 519.

[9]Sheehan *v.* North Country Community Hospital, 273 N. Y. 163.

Standards for Emergency Service

SISTER M. PATRICIA

THE Inter Hospital Committee of Duluth, Minn., which functions in place of a hospital council, is composed of the chief of staff and one other member of the medical staff, the hospital administrator and the superintendent of nurses of the four member hospitals: Hearding, St. Luke's, Miller Memorial and St. Mary's.

Among the procedures that have been adopted by the member hospitals following the recommendations of the committee are the following standards for emergency service:

Two bound books are kept in the emergency room at all times to serve as permanent records. These contain pertinent data regarding all emergency and accident cases.

Book 1 is labeled "Emergency Patients Who Have No Family Physician." In this book is placed an alphabetical list of all regularly appointed staff members who desire to answer emergency calls at the hospital. Some additional names are added from time to time as new members qualify for staff appointment. Members are listed upon their voluntary petition to the committee that is in charge of the emergency room.

Book 2 is labeled (1) "Emergency Patients Who Have a Family Physician," (2) "Emergency Patients Who Request a Specific Physician," and (3) "Emergency Cases Brought or Sent in by a Physician."

Books 1 and 2 have adequate space for the patient's name, address, name of employer, name of physician, the date and the disposition of the patient.

All cases in book 1 are reviewed and recorded as major or minor. Major cases include such cases as skull fracture, gun shot wounds, general fractures, tendon repairs or any patient who is considered seriously ill.

Each physician listed in book 1 is entitled to one major and one minor case in rotation. Attendance upon a minor emergency case has no bearing upon his rotation for a major case.

A copy of these rules is affixed as a permanent part of books 1 and 2.

When a patient is admitted to the emergency room, he is asked by the attendant: "What physician shall we call to attend you?" If the patient expresses no choice, his name is entered in book 1 and the physician next in turn is called.

When a patient chooses a physician, this physician must be called and the patient's name is entered in book 2. Attendance upon a patient listed in book 2 does not cause the physician to forfeit his turn in attending emergency cases.

Any physician listed in book 1 who refuses to respond to call forfeits his turn and reasons for such refusal are noted.

When a physician cannot be located, he does not forfeit the right to be called on the succeeding case.

Interns may at no time assume responsibility in these emergency cases. Adequate supervision by the physician in charge must always be provided.

Interns may at no time give information for insurance purposes and may not fill out blanks for insurance companies.

Forms entitled "Report of Emergency Case" are provided in the emergency room. These forms consist of a white original and yellow duplicate record on which the pertinent data, including x-ray diagnosis, are listed. These forms must be filled in at the time of service by the physician, intern or nurse, and the physician must sign the form.

Serial numbers are assigned to these forms, in addition to the hospital unit number.

If a patient is admitted to the hospital the original sheet is sent to the record room for filing. The duplicate is sent to the business office.

In cases of extreme emergencies, any available staff physician may render first aid but the regular family physician later assumes charge.

Sister Patricia is superintendent of St. Mary's Hospital, Duluth, Minn.

Trustees and Public Relations

P. J. PERINCHIEF

HOSPITAL public relations begins with its board of trustees and ends somewhere off in infinity. No one has ever fully defined hospital public relations. No one ever will. As long as hospitals continue to reflect the progress of medical science they will face new opportunities for service, new responsibilities to the community and new problems in public relations.

Because this article presents the viewpoint of the hospital trustee it is only fair that it start by placing upon the trustee the primary responsibility for hospital public relations, even though all the factors that contribute to the functioning of such a hospital are part of its public relations. Let us first dispose of that responsibility.

Fundamentally, the board of trustees is the community so far as the management and conduct of the hospital are concerned. It must stand for the community in its relationship to the administrator, the medical staff and the hospital personnel. It must stand for the hospital in the relationship of these elements in the institution to the community.

We must assume that the board of trustees is a carefully selected group of representative citizens of the hospital's service area. Without that factor any discussion of public relations is fruitless. The board of trustees must be the first standard by which the community measures its hospital on the one hand and by which the hospital, that is, the superintendent, doctors, nurses, technicians and employes, measures the community on the other.

Such a board of trustees will begin by being businesslike. It will hold regular meetings at least once a month. Its members will attend those meetings regularly or expect to be replaced by others who will attend. It will transact routine business with dispatch and pay the strictest attention to the reports and recommendations of the superintendent. The members will perform required committee duties and set an example in all matters relating to their service since, if the community representation to the hospital is slipshod, every element within the hospital will quickly reflect that attitude.

The trustee will be charitable. But he will remember that only justice, not charity, is blind. He will expect not to be treated as a reservoir of ready funds to be tapped at will by a careless administration. Thus, he will expect careful financial management by the superintendent and will be commensurately generous in his personal financial aid.

Mr. Perinchief speaks from the viewpoint of a trustee of a hospital of 75 beds, the only general hospital in a community of some 30,000 population

Having begun by being businesslike, the board will constantly keep in mind the importance of the financial relationship between the hospital and its patients. Without giving absolute precedence to any factor in hospital public relations it is safe to say that none is more important than the financial arrangement between the hospital and the patient. In this connection it is to be noted that public relief measures have greatly reduced the financial hazard in connection with indigent or borderline cases. Group hospital insurance is rapidly doing the same with respect to the middle class patient. But no public relations program is worth the name in a hospital in which the board fails to implant the knowledge that, because the hospital's services must be free in cases of necessity, they are never carefree in cases that can meet all or part of the cost of their care.

This businesslike board of trustees will be wise enough to confine any tendency to be hard boiled on the subject of finances to its intercourse with the responsible administrator and to see to it that the tendency does not creep into the daily dealings between the hospital and its patients. This calls for a dissertation on tact, which is not possible in the brief space of this article.

Every hospital that is rendering adequate service must appeal for funds beyond its operating income, return from endowment or auxiliary aid. The wise board of trustees will grasp this opportunity to place an accurate account of the hospital's service and the reasons for the deficit before as large a section of its community as possible. To proceed in this fashion serves as a sort of double check upon the hospital's own efficiency, since it is not only an invitation for contributions of money but also an open invitation for criticism. Pity that hospital that can't use both to advantage!

Finances, however, are only a part of the responsibilities of the trustee as they are only a part of the problem of hospital public relations.

From the lay point of view the woman's auxiliary plays a vital part in the hospital's community relations. An adequate auxiliary is more

Mr. Perinchief is treasurer of the Huntington Hospital Association, Huntington, Long Island, N. Y.

than a source of needed funds and supplies. The recognition of the auxiliary's importance to the hospital must begin with the board of trustees. In the Huntington Hospital, Huntington, Long Island, the auxiliary has a regular representative on the board of trustees. Not even members of the board are in as intimate daily contact with the hospital as are members of the auxiliary with their patients' library service, sewing groups and other activities. A hospital that does not appreciate these messengers of good will loses a tremendous advantage in its public relations.

The board's relationship to the medical staff cannot be overemphasized. Mutual respect is imperative. No hospital will progress far either in technical efficiency or in community recognition when the trustee assumes that he, as a representative of the community, has simply furnished the doctor with a workshop, in the management of which the doctor has no part.

No better point of view can be recommended for board and medical staff relationship than that which exists between the average citizen and his family doctor. It can be carried into the hospital relationship if the official intercourse between board and staff is reposed in a joint committee of equal representation. There is no greater leveler of opinion than the necessity to agree and, in such a committee, substantial agreement must be reached or it will be impossible to make even such vital decisions as that of membership on the staff and annual reelection to it.

All that has been said before is from the point of view of trustee responsibility. But all of these factors merge when the board of trustees transfers its responsibility to the administrator in charge. The finest of plans and programs from the outside can crash upon the rock of unsympathetic, inefficient and incompetent management within the hospital. Here we leave the field of theory and reach the practical, since the hospital in action is its own public relations department.

Before the responsible board of trustees does any of the things suggested it will have selected a competent administrator. If the board is responsible and responsive, the arm of that administrator will be strengthened at its most vulnerable point.

There will be more harmonious relations among practitioners within the institution and equal understanding between the practitioners and the hospital personnel. Patients will be people, not just cases, to everyone from the reception clerk to the anesthetist. And the hospital, instead of being a fearsome bogey to be shunned, will become the prized possession of the whole community.

WHAT THEY ARE SAYING

Doctors and Service Plans

• "The advice and counsel of the family doctor is invaluable to us. In planning with hospitals, the doctors should play a large part in the formulation and operation of service plans. It is only by joint action between the members of the medical profession and the hospital administrators that we may arrive at a successful solution that is mutually beneficial to all."—PAUL KELLER, M.D., *Associated Hospital Service, New York.*

For Three-Thirds of the Nation

• "In a recent address a prominent exponent of organized medicine asked the rhetorical questions whether we wanted England's, Hitler's, Stalin's or New Zealand's medicine or American medicine; whether we wanted socialized, state or democratic medicine. The expected answer is that for America we want American democratic medicine.

"What is this and how should it develop to be something truly American, truly democratic and truly medicine in the best sense of the word? It must be public health medicine, which means that it is preventive as well as curative, that it is medicine delivered without distinction as to race, creed, occupation or income, and that it is for no less than three-thirds of the people.

"Any bill that becomes a law after being duly considered and enacted by an American legislative body, provided it is constitutional, is American and is democratic. Some things we have brought from abroad. We have adapted them to our ways and usually improved them. There is no reason why we should not adapt, develop and improve any form for the social organization of medicine that may be suggested by the experience of other countries."—EDWARD S. GODFREY JR., M.D., *New York State health commissioner and president of the American Public Health Association.*

Philanthropy or Taxes

• "Does New York need the voluntary hospitals? Of course; the answer can be nothing but yes. Obviously, the city at no time can take over the entire hospital system of New York.

"Suppose the city did take on the burden? I don't know of anything a government ever did that did not cost half as much or twice as much as could be done under private enterprise.

"We might just as well give our money as charity. Better do that than have it extracted from your pocket by the tax collector.

"If the general public had more knowledge of the work of the hospitals, even the fellow on the street who could afford only half a dollar would contribute."—ALFRED E. SMITH, *former governor of New York.*

Industrial Health

• "Industrial leaders of the country should develop a national health program for their employes. . . .

"Relatively few manufacturing establishments have the benefit of expert guidance and a large proportion of the workers are employed in plants that are served by general practitioners who have little knowledge of occupational disease exposures and are not interested in them, preferring to treat injuries.

"If industrial concerns would carry out a program to take care of appendicitis, cancer, pneumonia, anemia and the communicable diseases, as well as injuries, then many of the injuries might be prevented and the workman would be better able to perform his job. . . .

"To a large degree the study of diseases that result from the occupation of the worker is the basis for the treatment of all diseases, since it brings a doctor into a home not only to treat the worker but also to find cases of chronic or acute conditions in members of his family."—C. D. SELBY, M.D., *medical consultant, General Motors Corporation.*

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Inspection Without Infection

MARIE ROWLEY, R.N.

Left: Fig. 1 illustrates the cellophane canopy that fits over the bassinet so that the infant may be transported to conferences without danger of contamination. Below: Fig. 2 is the shield used for otologic examination, and Fig. 3 is the ophthalmological shield.

ON A pediatric ward the need for rigid aseptic technic is obvious. The children range in age from 1 day to 4 years and not all of them enter the hospital with infections.

The children's ward of Mount Sinai Hospital, New York, is equipped with isolation facilities. Babies up to 7 months of age lie in Pirquet cubicles and older children are in small separate rooms or in double rooms with glass partitions. In spite of these precautions, upper respiratory and gastro-intestinal infections, which are probably spread unwittingly by the medical and nursing staff, occasionally appear.

Loyal cooperation between the nursing and pediatric staffs, as well as between the pediatric staff and the consulting services, is essential for the conduct of an aseptic regime.

Parents are not permitted to touch children in the Pirquet cubicles. They are instructed to wash their hands before handling older children and are discouraged from fondling them. Furthermore, they are closely questioned as to colds and exposure before they are permitted to enter the ward or the children's rooms.

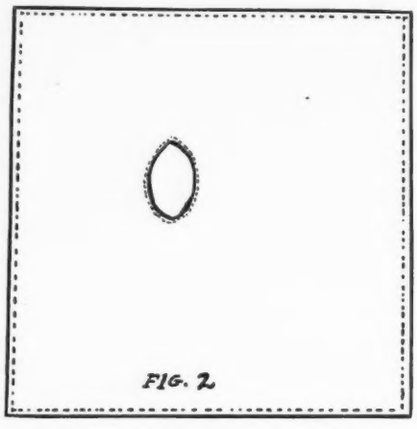
Visitors must wear gowns at all times and masks during the seasons when colds are prevalent.

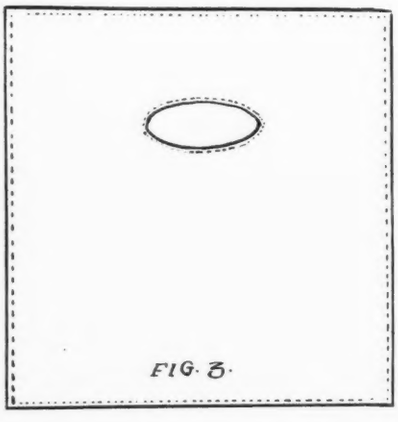
Other dangerous sources of infection come into play when extradepartmental procedures and examinations by special services necessitate the child's leaving the ward. For instance, when a patient goes to the x-ray department, the nurse who prepares and accompanies the child to that department is instructed to be the only person to handle him; she adjusts him in the desired position, acting upon instructions from the x-ray technician. The same rule is enforced in the electrocardiographic, photographic and other departments.

The transportation of infants to conferences and their presentation have always been a matter of grave concern to us. Taking a child from a clean unit into a crowded conference room is contrary to our concept of aseptic technic, particularly during the season when respiratory infections are prevalent.

In order to minimize the danger of exposure, the child usually is shown for a few minutes only. Consequently, only those seated in the front row get even a partial view of the patient. In the end, the conference fails in its primary aim to present a clear visual picture correlated with the case history.

In order to conduct a good teaching program for medical or nursing students, the demonstration of clinical material is imperative. To accomplish this the following points are essential: (1) the child must be





Miss Rowley is in the pediatric department of Mount Sinai Hospital, New York.

protected as far as possible from exposure to outside contact and to differences in room temperature, and (2) the student must get an adequate visual picture of the child, his general appearance, the clinical picture of the present disease and his behavior.

In order to meet these requirements adequately, a canopy (fig. 1) was devised. This is made of cellophane and fits over a bassinet, completely covering the top and sides and falling to a few inches below the mattress. The canopy is rather loose around the sides, permitting some air to circulate upward into the bassinet. It has been suggested that a few air-holes may be provided at each end of the canopy to ensure free circulation of air but, inasmuch as the child is in the bassinet for a short time only, this seems unnecessary. It has also been suggested that one side have a slide fastener that would permit ready access to the child without removing the canopy. This suggestion could easily be carried out. The advantages of the canopy are:

1. Protection against exposure to infections. The child can be observed without exposure for a longer period of time by a larger number of students.

2. Economy of nurse's time. The nurse can prepare the child, undress him, feed him before the conference, place him in the bassinet, adjust the canopy and wheel the bassinet to the conference at the desired time.

3. Less danger of exposure in transit and no contact with other patients. The temperature during transportation can be maintained in cold weather by placing a warm blanket over the canopy or in warm weather by using a sheet.

4. The possibility of demonstrating two or more patients at the same time for comparison.

5. Ease of washing with soap and water or alcohol or airing it in the sun. It is inexpensive, therefore, an adequate supply can easily be provided.

There exists still another source of infection on the pediatric ward, which is involved in the need for otologic examinations performed by the pediatric staff or by the special staff of the otologic department. This examination brings another group of physicians into close contact with the child. Schick, in discussing this problem, has proposed covering the nose and mouth of the child with a towel during the examination. This method may irritate or frighten an already apprehensive or hypersensitive child. A better and simpler method has been devised.

Figure 2 is a cellophane shield for use in otologic examinations. It is a square piece of cellophane, 30 by 30 centimeters, with an oval opening through which the ear lobe can be exposed while the nose and mouth of the child are covered. The cellophane permits the child to see what is happening, thus allaying apprehension and facilitating a more satisfactory examination of the ear.

Of equal importance is the protection of the child during an ophthalmologic examination. The use of a towel over the nose and mouth causes too much discomfort to the patient since it adheres to the face and obstructs breathing. A cellophane shield with a different opening (fig. 3) may be used. This light shield does not adhere too closely to the face. The advantage of this shield, particularly when dealing with children suffering with encephalitis or meningitis, is that it protects both child and physician.

The cost of the shields is so slight and their value on a pediatric ward so obvious that their use should be encouraged.

The greater time consumed in carrying out these measures will be amply repaid by shortening the period of hospitalization of the patient and by eliminating, or at least reducing, cross infections that are frequently responsible for the delay of discharge.

Evolution of a Bandage Winder

FRANCIS W. BISHOP, M.S.,
and EMMY LEHMANN, R.N.

MANY institutions have found that a considerable saving can be effected by making some of their own supplies, even when these are made more or less by hand. A number of extremely simple devices have been developed that have as their purpose the speeding up of the manufacture of such important articles as bandages.

At Strong Memorial Hospital, Rochester, N. Y., we formerly used a crude type of winder by which the bandage was wound on a spindle that was turned by hand. This device was slow and clumsy. We decided, therefore, to devise some type of motor-driven bandage winder that would combine speed with simplicity of operation and yet not be too expensive. An old dictating machine was examined and found to be adaptable to the purpose with a few mechanical changes that could be made by the hospital machinist.

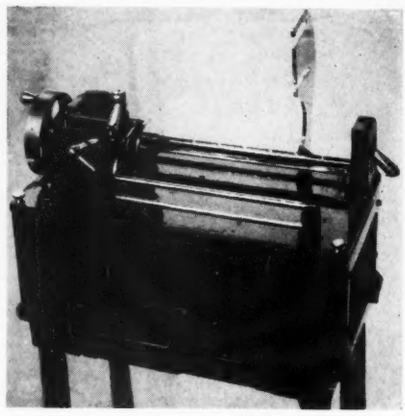


Fig. 1—Winder mechanism in position to remove finished bandage.

Figure 1 shows the completed bandage winding machine. The record ejecting device was left almost intact, the only change being to braze a ⅛ inch thick disk of metal about 2 inches in diameter at the external part of the disk ejector mechanism. This disk has a hole through its center to permit the passage of the winding spindle. The bandage ejector supplies the push necessary to start the wound bandage along the slightly tapered spindle.

The authors are associated with the Strong Memorial Hospital, Rochester, N. Y., in the department of radiology and the surgical supply room, respectively.

Boxed Bananas

are especially adapted for hospital use

BOXED BANANAS ARE:

Relatively uniform in quantity, size and degree of ripeness

• • •

Relatively free from bruises

• • •

Dependable for accurate planning of quantity serving

• • •

More convenient and satisfactory to use

• • •

More economical because there is no waste

IT is safe to say that hospitals which buy boxed bananas (detached "hands" packed in boxes) will not return to the old purchase-by-bunch method, because they are now regularly satisfied banana customers.

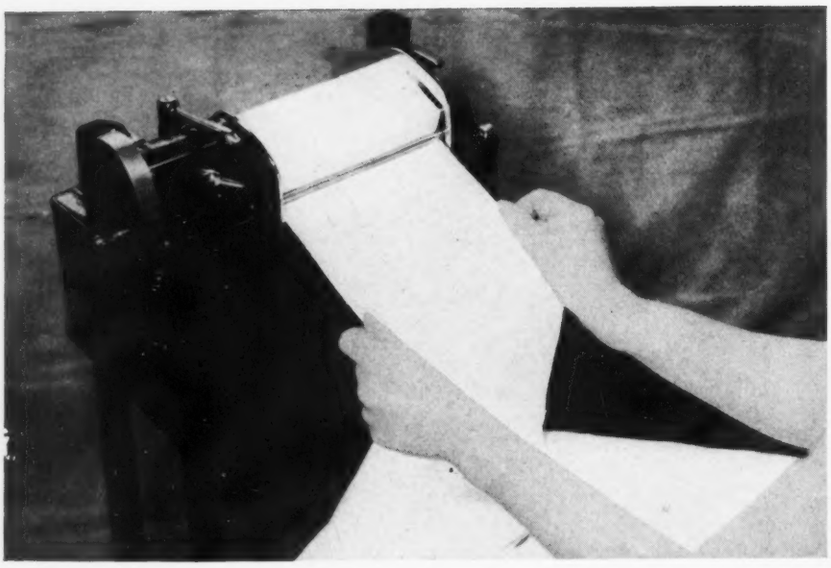
The usual practice of the wholesaler is to fill his banana orders on either of these two specified degrees of ripeness..."Turning Fruit" (still showing partly green color and green tip) or "Hard Fruit" (full yellow color or with only slightly green tip). Hospitals therefore should follow these specifications when placing their banana orders.

Because bananas are a delicate tropical fruit, they should be placed in a room with comfortable temperature (65 to 70° F.) as soon as they are received in order to become completely ripe (mellow with golden peel flecked with brown) before using.

This bland, nourishing fruit—well liked by most people—has found many uses as a food in the hospital. It contains vitamins A, B, C and G as well as essential minerals and thus helps protect against deficiency. It is an important item in many special diets.

For free, tested banana recipes, in quantity proportions, write to Fruit Dispatch Co., Home Economics Dept., Pier 3, North River, N. Y. City.

Include BANANAS on your menus regularly for both Patients and Personnel { **Few foods give so much value for your money!**



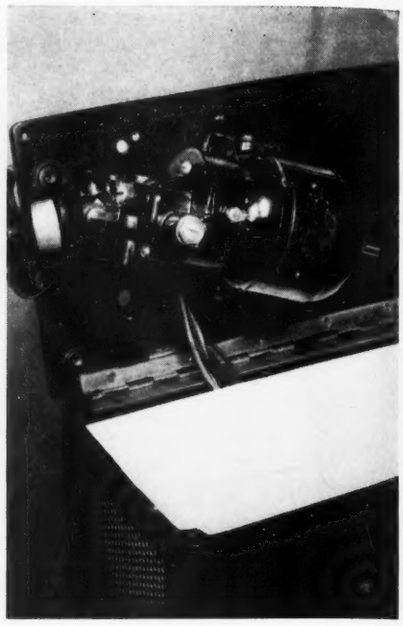


Fig. 2 (above)—Operator holds bandage in position for winding. Fig. 3 (right) —The machine is hinged back to show motor mounting and driving gears.

The shaft and gear mechanism that usually turns the record was removed and a new shaft, which is sufficiently long to accommodate the widest bandage used, was installed. Beginning at the point where it emerges from the gear housing, this shaft is milled square and with a slight taper so that the bandages slide off easily. A small hole was drilled into the free end of this shaft so that a hinged support is engaged when a bandage is being wound. This end bearing is pushed to one side to permit removal of the finished bandage. The casting that supports the end bearing of the record drum was cut off flush with the gear housing and a new bearing installed at this point. The rim of the wheel that usually carries the belt was turned off flat for the sake of appearance and a small handle screwed to the face so that the outfit may be wound by hand, if desired, or in event of motor failure. The wheel was rigidly fastened to the bandage spindle.

Guide for Various Widths

A movable guide for the bandage widths was mounted on one of the rods on the back of the machine. This guide is slotted so that it will pass over the drive spindle and tension rods. The guide plate is shown raised in figures 1 and 2 in the position for a 6 inch bandage.

The usual motor drive was removed from the apparatus and a type CR-2, 5000 r.p.m. motor, 1/80 h.p. with a gear reduction of 35 to 1 was installed. The slow speed shaft was extended to reach the spindle shaft and a steel bevel gear was placed on the end of the driving shaft. This bevel gear engages a similar gear on the spindle.

Bandage Can Be Unwound

In order to permit the disengagement from the motor either to use the hand crank or to allow the bandage to be unwound slightly if it becomes folded in winding, a gear shift was provided, using parts of the clutch mechanism. In the present instance, the bevel gear was slid along the spindle shaft by a cam, the handle of which is illustrated in figures 1 and 2. When the gears are engaged the mechanism is such that the sliding gear is locked in place and does not disengage with the load. The mounting of the motor and the bevel gears are visible in figure 3.

Two of the external high parts of the casting were cut down for the sake of appearances and a small support was added on the front part of the machine to carry two rods that act as a bandage tension device. These, supported from the new post on the right and from a bandage guide plate on the left, are shown in figure 1. In figure 2 the bandage is shown threaded through the tension rods. Because the direction of rotation is reversed, the clutch and drive mechanism of the machine were discarded and the bevel gear drive was installed.

It is possible further to improve the belt drive in the dictating machine and retain some of the mechanism, such as the clutch, if there is no objection to winding the bandage from the bottom; or the toothed clutch may be altered to permit rotation in the reverse direction.

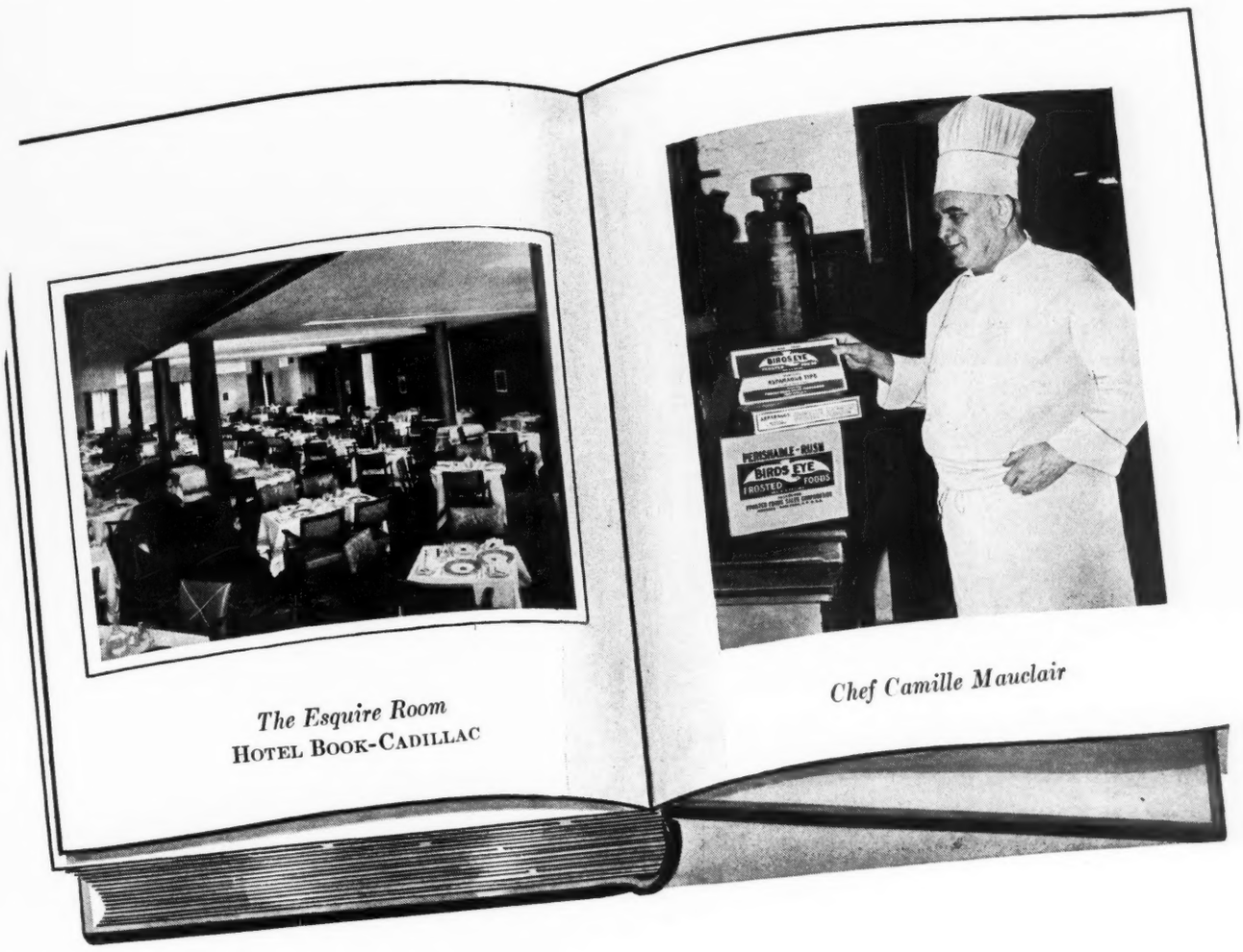
Tension Rods Hold Material

The bandage width guide may be dropped into slots at spaces of 1, 2, 3, 4, 5 and 6 inches in order to accommodate bandages of these widths. To operate the device, the bandage is threaded through the tension rods as shown in figure 2 and the operator sets the mechanism in motion. by stepping on a foot switch. When the bandage is wound the movable guide is hinged back and the ejector lever is moved to the right which shifts the bandage along the tapered spindle for about half an inch. The end bearing is then swung out of the way and the finished bandage is removed.

The complete machine is mounted on the usual stand and is, therefore, easily moved from place to place.

The authors are indebted to the Dictaphone Sales Corporation, Rochester, N. Y., for providing the machine used to make the bandage winder.

Here's the Answer from the Back of "The Book"



The Esquire Room
HOTEL BOOK-CADILLAC

Chef Camille Mauclair

FROM ITS national reputation for mouth-watering food . . . you might expect Detroit's Hotel Book-Cadillac to advance some fabulous formula for successful restaurant operation.

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Yes, food whose pre-cooking quality is so high that every meal served in the Esquire Room, the Book Casino, and Cafe Cadillac becomes a glorious table experience!

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Clean Dishes and Clean Pans

MARY deGARMO BRYAN

THE importance of clean dishes as they affect the cleanliness, sanitation and attractiveness of food is nowhere of more importance than in feeding hospital patients. Most hospitals, in which conditions permit, are equipped with dishwashing machines and these provide the quickest, most efficient means of cleaning dishes.

Manufacturers advise certain procedures in connection with dishwashing machine operation which reduce or destroy respiratory or salivaborne infections and those that may be transferred to the dishes by direct contact of the hands of a diseased person. The dishwashing process does not sterilize but is, instead, a "pasteurization," as that term is currently understood.

In the dishwashing machine the dishwashing process is divided into two steps. First, the dishes are sprayed with a warm water containing a detergent. The primary function of the wash is to remove soil from the dishes. The temperature of the water, therefore, is set below the coagulation point of food proteins but high enough to facilitate the removal of fats. The best current practice for single tank machines recommends a washing time of from thirty to forty-five seconds at a temperature of approximately 140° to 150° F.

The time stated is sufficient to cleanse the dishes unless food has been permitted to dry on them. This brief exposure is probably not sufficient to destroy bacteria but a temperature of 140° F. serves to inhibit rapid development of bacteria in the wash water, provided it is reasonably free from soil. When mass soil is present, this temperature is not effective. It is important, therefore, that wash water be changed at least every hour or more frequently.

The author is head of the department of institution management, Teachers College, Columbia University, New York.

In two tank machines a rinse, as well as a wash tank, is provided but a clean, hot water rinse should be used as in the single tank machine. The wash period may be slightly shorter. A 20 inch clear rinse is recommended.

The wash tank is constantly refreshed by the addition of the rinse. Large particles of food are removed by the strainer beneath the racks, but small particles and bacteria accumulate in the wash water and adhere to the dishes to some extent.

The most frequently used detergents on the market for mechanical dishwashing contain one or more of the following ingredients: trisodium phosphate, sodium metasilicate, sodium carbonate, sodium hydroxide, sodium hexametaphosphate and tetraphosphate. The action of detergents is physical. They facilitate cleaning by lowering the surface tension of fats and by emulsification. Reports on bacteriacidal action of detergents have indicated some bacteriacidal effect by those containing hexametaphosphates, though the constant change in concentration of the wash solution would tend to make this a relatively unimportant factor in the cleaning process. Detergents, however, prevent the precipitation on the dishes of the insoluble film which holds bacteria and reduces the efficiency of the rinse.

The second step of the process consists of the exposure of the dishes in the rack to a clean, hot water rinse under pressures of from 25 to 50 pounds from a hot water line. The temperature of the rinse should be at least 180° F. and the time of rinsing should be from ten to fifteen seconds for the removal of wash water and for "pasteurization." (Experiments with new types of the electric pasteurizers, of which four kinds are accepted in New York State, have shown that pathogenic organisms are destroyed at temperatures of from 160° to 165° F. in approximately eleven seconds.) The primary function of the rinse is to remove all particles of soil and bacteria, leaving a clean surface to which bacteria will not adhere.

If the rinse water is sufficiently hot and if the dishes are exposed for ten or fifteen seconds, both dishes and glasses will dry rapidly by evaporation, provided that there is sufficient clean dish space to permit the racks to stand for a few minutes. Newer types of dish racks in which the dishes may be stored on shelves or in warmers without transfer are especially desirable.

Glasses need not be wiped provided that there is not an excessive amount of detergent in the wash and that the detergent has been com-

Mechanical dishwashing is only one sanitary factor in hospital food service, but it is an important one. Even with the aid of the latest dishwashing machines and equipment, details of this process must be given special attention by the dietary department personnel

pletely removed by the rinse. In hard water areas, it may be desirable to use water softeners as well as hexametaphosphate detergents to avoid cloudy glassware.

Silver will dry without toweling if washed and drained standing on end rather than lying flat, assuming that the 180° or 190° F. rinse is used and there is space for drying. It may require some time to place silver on end in suitable racks but this time is less than that required to dry it by hand. Sanitary advantages of drying without toweling are obvious.

The efficiency of all types of machines is dependent upon the thoroughness with which the dishes are scraped. All dishes should be carefully scraped and stacked before being placed in the dish racks; excessive grease should be removed with a paper napkin. If badly soiled dishes are placed in the machine, the wash water becomes a dilute garbage in a short period of time.

Other factors in efficient operation relate to the machine and its care. They include the position of the dishes in the wash chamber, the mechanical action and pattern of the wash arms, the volume of the tank and the pressure of the water sprayed over the dishes during the wash and rinse periods. These features should be compared in several makes of machines before purchase. Warmth and humidity of the dish machine favor the growth of bacteria. All parts should be made of materials that are smooth and readily freed from adhering food and bacteria. The use of stainless steel tanks is particularly desirable and the thorough cleaning of the entire machine after each use is essential.

Maintaining Temperature

Another factor determining the success of the process is the provision of methods to ensure the maintenance of proper temperatures. All first-class machines are now provided with thermostatic control of the wash water temperature; only machines having this device should be purchased. The second control feature is a thermometer in the hot water rinse line that indicates the temperature of the rinse water. Many boards of health now require the installation of such a thermometer. If hot water is produced at some distance from the dishwashing unit, it may be necessary to install a small booster heater in the hot water line in order to obtain temperatures of 180° to 190° F. at the spray arms.

In a good many hospitals, it is not possible to provide dishwashing machines. In institutions in which dishes must be washed by hand, the glasses, silver and dishes should be thoroughly scraped, washed in warm, soapy water, rinsed in warm water and placed in a wire rack. Boiling water should then be poured over them and they should be allowed to dry without toweling.

No discussion of the cleaning of food utensils should omit the washing of pots and pans. The spectacle of pans being washed in a sea of greasy water full of particles of food not only is revolting but accounts for the poor flavor of the food cooked in such utensils. In many kitchens the pots and pans are never really cleaned. They should be thoroughly scraped, washed in hot, soapy water, which is changed frequently, and rinsed in clean hot water.

Suggests Drying by Steam

The newest sinks for the cleaning of pots and pans provide three compartments. One is for the scraping and rinsing of the utensils so that all possible food is removed. This compartment is provided with a faucet for rinsing the utensils but has no plug or gate valve in the drain; a drain strainer only is provided. In the adjoining compartment, the pots are scrubbed in warm soapy water. In the third compartment, the pots and pans are rinsed in clean, hot running water. One dietitian suggests one or more shelves heated with steam coils for drying the utensils. If utensils are dried by wiping, towels should be immaculately clean and plentiful and should be laundered after each time they are used.

All sinks should be of stainless steel for ease of cleaning. They should be shallow so that the amount of water which may be kept in the sink at any time is small and can be changed frequently. Twelve to 14 inches is maximum depth. They should be placed at least 38 inches from the floor if men are used as potwashers; 40 inches is sometimes preferred, so that the worker stands upright at his task. Dishwashers and potwashers should be sufficiently intelligent to understand the reasons for the methods used; they should be carefully instructed in every step, should be provided with necessary equipment, including a clock, and should be supervised frequently. Probably some of the carelessness arises from inadequate inspection by health authorities and from difficulties in carrying out the method prescribed by law.

Study of local and state legislation regulating methods of cleansing dishes reveals entire lack of uniformity in method. In some instances, the regulations are impracticable and may actually defeat their aim. It would seem that the recent provision of New York State, in which the end rather than the means is specified, would be one reasonable method of regulating the dishwashing process.

A section of the sanitary code as amended June 1939 specifies: "All eating, drinking and cooking utensils shall be so cleansed and disinfected as to be free from bacilli of the coliform group and to have a total bacterial count of not more than 100 per utensil as determined by test in a laboratory approved for the purpose by the state commissioner of health." Further study is necessary in order to establish methods of washing dishes which will meet with the approval of boards of health and which are feasible under average operating conditions.

Other Sanitary Factors

In describing some methods of providing safe and shining dishes and pans, it is important to bear in mind that other factors of sanitation, which are closely connected with clean and sanitary utensils, are entirely overlooked in many hospitals. For example, dishes are often handled after washing by employes who are never examined for communicable diseases or who have inadequate toilet and handwashing facilities. Glasses and silver — the utensils coming in contact with the mouth of the patient—are toweled and the towels are frequently dirty. Similar omissions of careful sanitary procedure stress the fact that the washing of the dishes is only one link in the chain of real cleanliness.

Diet in Sulfanilamide Therapy

LOVENTRICE TURNER

This article presents four important points to be kept in mind in regard to the dietary needs of patients who are being treated with sulfanilamide. Variations in caloric, glucose and protein intake are discussed

IT IS not necessary to modify a patient's diet during treatment with sulfanilamide since no specific foods are contraindicated unless the patient requires a special diet. It is well to consider, however, the changed body requirements, which vary with the severity of the infection present and thus furnish necessary reenforcements for normal functioning and protection of the body.

In most cases in which sulfanilamide is prescribed, the ability of the patient to digest, assimilate and absorb foodstuffs is temporarily retarded and the basal metabolic rate is increased. The degree of variation from the normal adequate diet will be dependent upon the changed functional state of the gastro-intestinal tract and any other abnormal clinical manifestations. Since each case will naturally present a different problem, no absolute dietary standards can be stated; however, the fundamental nutritive needs of the patient should receive careful consideration by the attending physician and dietitian.

Dietary Modifications

Generally speaking, the dietary modifications that demand the most consideration in order to bring about the desired progress of the patient will include: (1) caloric intake; (2) protein intake, and (3) total glucose in the diet. A brief discussion of these dietary standards follows:

Caloric Intake: Since the basal metabolic rate is increased in all diseases accompanied by a fever, the caloric intake of patients receiving sulfanilamide should automatically be increased proportionately to supply the necessary energy demands. An increase of from 30 to 50 per cent above the maintenance caloric requirements is usually desirable. The foods selected should be easily digested and utilized by the patient, and in most cases the concentrated carbohydrate foods are preferred. They serve the double purpose of supplying energy and increasing the total available glucose in the body. Other advantages of high carbohydrate foods in preference to those that are high in fats would include rapid digestion, absorption and assimilation, as well as esthetic appeal.

Nausea is frequently associated with cases that receive sulfanilamide not from the administration of the drug but as a result of the infection present; hence, foods high in fat are usually given in moderation. Three small or medium sized meals with three between meal feedings of fruit juice reenforced with glucose or some other simple sugar offer an acceptable feeding routine. Some cases may require second or third hour feedings of liquid or semisoft foods. The texture of the food served will depend on the severity of the symptoms manifested and the general physical condition of the patient. The usual routine is to force fluids during the acute stage, then progressively increase the diet introducing solid foods as tolerated.

Protein Intake: The nominal protein standard of 1 gram per kilogram of ideal body weight should be the minimum allowance, and in cases in which active protein destruction is pronounced the protein intake should be increased to from 1.5 to 2 grams per kilogram of ideal body weight. The allowance of protein should be prescribed by the attending physician and any increase above the normal standard must be left to his discretion. The foods preferred in supplying the protein while the patient is on a liquid or semisoft diet are milk, eggs, cereal gruels, cottage cheese and gelatin. Meat, fish and cheeses, other than cottage cheese, should be included when solid foods can be tolerated.

Total Glucose in Diet: The available glucose in the diet should be increased as an aid in combating the infection present, minimizing the work of the digestive tract and supplying sufficient energy for the patient. In cases that are not complicated by diabetes mellitus, the minimum glucose intake should be 300 grams with increased allowance as needed and tolerated by the patient.

Treatment of Diabetic Cases

Patients with diabetes mellitus who are receiving sulfanilamide will usually show better results on diets that supply from 250 to 300 grams of glucose daily. Higher allowance may be given if necessary. This will necessitate an increased dosage of insulin. However, no ill results are noted from this variation of routine treatment since the time interval is short and readjustment of the diabetic patient can be established as soon as the infection is under control. Care must be exercised when sulfanilamide is given since it alone may offset the insulin requirements, owing to the fact that it produces an acidosis as the result of loss of base. Thus, it is not infrequent that a diabetic patient's insulin requirement rises as a result of sulfanilamide treatment, aside from any rise caused by dietary increases.

It is assumed that the mineral and vitamin requirements will be met in the process of supplying the additional calories and increasing the protein intake. In case there is any doubt regarding their content in the diet, accurate calculation of minerals and vitamins is advocated.

Miss Turner is assistant to the director of nutrition, Western Pennsylvania Hospital, Pittsburgh.

Figuring Food Costs Rapidly

GRACE STOWELL SAUNDERS

Supervisor of School Cafeterias
Board of Education, Syracuse, N. Y.

MOST fundamental in maintaining the cost of food purchases on a normal percentage basis, considering the type of food business conducted, is the accurate and constant figuring of all recipe and portion costs. All will agree that this detail in cost control is most intricate and consumes a great deal of time. However, through the use of the accompanying charts and other similar ones, purchasing costs of all food items may be figured with accuracy.

To illustrate the use of this method of figuring costs, three charts are presented, namely, (1) fresh green peas, (2) canned green peas, (3) frosted green peas. With their use edible portions of fresh, canned and frosted peas are quickly determined.

In preparing the charts certain basic factors are applied, such as the commercial classification of food as purchased so the identity of the food charted may be at once established. To illustrate, peas may be purchased as local or southern fresh, canned or frosted; can sizes may be No. 10 or No. 2 with different net and drained weights. Also other factors affecting costs are commercial gradings, composition, age, size, shrinkage and preparation wastes.

HOW TO USE THESE TABLES

In the first line of the appropriate table, locate the price of the peas. Running down this column you can quickly find the price for a serving of any size from 1 to 4 ounces, as well as the price for 1 pound of the edible portion. For example, if frosted peas cost $.43 for a 2½ pound package, the cost per three ounce serving will be found to be $.0323.

The purchasing prices shown are based on actual prices which include low and high price levels for each food item. In preparing the Fresh Green Peas Chart, southwestern fresh Early June peas were used in the tests made as the local fresh were not available. The price range covers hamper lots of 28 pounds and wholesale purchasing costs as of May 1939. All costs are cut down to a 1 pound, or 16 ounce, basis. The peas were shelled and the actual weights of pods and shelled peas are given. Of course, when preparation wastes reach an appreciable amount, as in the case of green peas, the actual cost of the edible portions is relatively higher. Such changes in cost are always computed and tabulated. All portion costs are figured in ounces from 1 ounce to 4 ounces.

PEAS—Fresh Green in Pod

VARIETIES: Southwestern Fresh, California

	COSTS, AS PURCHASED								
28 lb. hamper	1.50	1.75	2.00	2.25	2.50	2.75	3.00	3.25	3.50
1 lb.	.0536	.0625	.0714	.0804	.0893	.0932	.1071	.1161	.125
1 oz.	.0033	.0039	.0045	.005	.0056	.0061	.0067	.0073	.0078
2 oz.	.0067	.0078	.0089	.01	.0112	.0123	.0134	.0145	.0156
	COSTS, EDIBLE PORTION								
1 lb.	.1428	.1667	.1904	.2143	.2381	.2619	.2857	.3095	.3333
1 oz.	.0089	.0104	.0119	.0134	.0149	.0164	.0179	.0193	.0208
2 oz.	.0179	.0208	.0238	.0268	.0298	.0327	.0357	.0387	.0417
3 oz.	.0268	.0313	.0358	.0402	.0446	.0491	.0536	.058	.0625
4 oz.	.0357	.0417	.0476	.0536	.0595	.0655	.0714	.0774	.0833

More accurate to buy by weight; range of prices covers Southwestern Fresh only; time is an item of cost unless hulling is done by machine.
1 lb. as purchased = 6 oz. edible portion.

PEAS—Canned Green

VARIETY: Early June SIEVE: Combination

	COSTS												
No. 10, 1 doz. cans	5.25	5.50	5.75	6.00	6.25	6.50	6.75	7.00	7.25	7.50	7.75	8.00	8.25
No. 10 can	.4375	.458	.479	.50	.5208	.5417	.5625	.5833	.6042	.625	.6458	.6666	.6875
1 lb.*	.0929	.0964	.1008	.1051	.1096	.1139	.1184	.1227	.127	.1315	.1358	.1403	.1446
1 oz.*	.0057	.0060	.0063	.0066	.0069	.0071	.0074	.0077	.0079	.0082	.0085	.0088	.009
2 oz.*	.0114	.0120	.0126	.0131	.0137	.0142	.0148	.0153	.0159	.0164	.017	.0175	.0181
3 oz.*	.0171	.0180	.0189	.0197	.0206	.0214	.0222	.023	.0238	.0247	.0255	.0263	.0271
4 oz.*	.0228	.0240	.0252	.0263	.0274	.0285	.0296	.0307	.0318	.0329	.0351	.0351	.0362

*Drained peas are generally served; consequently, costs are figured on the drained weight basis.
No. 10 can = 112 oz. net weight or 76 oz. drained weight.

PEAS—Frosted Shelled Green

VARIETIES: Laxton, Laxtonian, Alderman 200, Telephone
SIEVE: Garden Run

	COSTS																			
2½ lb.	.37	.38	.39	.40	.41	.42	.43	.44	.45	.46	.47	.48	.49	.50	.51	.52	.53	.54	.55	.56
1 lb.*	.148	.152	.156	.16	.164	.168	.172	.176	.18	.184	.188	.192	.196	.20	.204	.208	.212	.216	.22	.224
1 oz.*	.0092	.0095	.0097	.01	.0103	.0105	.0108	.011	.0113	.0115	.0118	.012	.0123	.0125	.0128	.013	.0133	.0135	.0138	.014
2 oz.*	.0185	.019	.0195	.02	.0205	.021	.0215	.022	.0225	.023	.0235	.024	.0245	.025	.0255	.026	.0265	.027	.0275	.028
3 oz.*	.02775	.0285	.02925	.03	.0308	.0315	.0323	.033	.0338	.0345	.0353	.036	.0368	.0375	.0385	.039	.0398	.0405	.0413	.042
4 oz.*	.037	.038	.039	.04	.041	.042	.043	.044	.045	.046	.047	.048	.049	.05	.051	.052	.053	.054	.055	.056

*Drained peas are generally served; consequently, costs are figured on the drained weight basis.
Case 8: 40 oz. packages (2½ lb. per package); Case 10: 80 oz. packages (5 lb. per package).

Compare:

KNOX GELATINE (U.S.P.)	FACTORY-FLAVORED GELATIN DESSERTS
All gelatine.	Only contain 10 to 12% gelatine.
Protein 85%.	Protein 10 to 12%.
pH about 6.0.	pH highly variable.
Absolutely no sugar.	85% sugar average.
No flavoring. No coloring. Odorless. Tasteless. Blends well with practically any food.	Contain flavoring, acid and coloring matter.
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March Menus for the Small Hospital

	Breakfast		Luncheon or Supper				
Day	Fruit	Main Dish	Soup or Appetizer	Main Dish	Potatoes or Substitute	Vegetable or Salad	Dessert
1.	Orange Slices	Milk Poached Eggs on Toast	Tomato Juice Cocktail	Creamed Tunafish	Baked Potato	Apple and Orange Salad	Peppermint Tapioca, Chocolate Sauce
2.	Tomato Juice	Cornmeal Griddle Cakes, Syrup	Cream of Mushroom Soup	Spinach With Bacon and Hard Cooked Egg on Toast		Black Cherry and Pineapple Lemon Gelatin Salad	Baked Custard
3.	Pineapple Juice	Scrambled Eggs, Cornbread	Fruit Cocktail	Liver en Casserole	Boiled Potatoes	Head Lettuce, Roquefort Dressing	Chocolate Chip Bread Pudding
4.	Prune Juice	Sausages and Apple Rings, Toast	Broiled Half Grapefruit	Mock Chicken Legs	Creamed Potatoes	Tomato and Lettuce Salad	Butterscotch Tarts
5.	Dried Fruit Compote	Bacon and Eggs, Blueberry Muffins	Grape Juice	Spanish Pie	Buttered Parsnips	Shredded Carrot, Raisin and Coconut Salad	Vanilla Ice Cream, Cookies
6.	Orange and Grapefruit Juice	Soft Cooked Eggs, Bran Muffins	Bouillon	Creamed Chicken and Mushrooms in Potato Shells	Buttered Beets	Raw Spinach Salad	Peach Cobbler
7.	Cranberry Juice	French Toast, Honey	Fresh Fruit Cup	Baked Shoulder Lamb Chops	Mashed Potatoes	Tomato Salad	Gingerbread, Whipped Cream
8.	Sliced Oranges	Scrambled Eggs, Berry Flake Muffins	Tomato Juice, Rye Krisp	Escalloped Crab Meat, Brazil Nut Crust	Hash Brown Potatoes	Buttered Frozen Peas	Fruit Gelatin, Whipped Cream
9.	Grapefruit Juice	Wheat Cakes, Syrup	Chilled Pineapple Cocktail	Liver and Onions	Buttered Noodles	Broiled Tomatoes	Graham Cracker Cake
10.	Applesauce	Shirred Eggs, Hot Rolls	Celery Broth	Ham and Egg Nests	Browned Rice	Shredded Lettuce, French Dressing	Cherry Sauce, Cookies
11.	Stewed Figs	Bacon Omelet, Toast	Grape Juice	Whole Meal Stew	Corn Muffins, Honey	Shredded Cabbage Salad	Chilled Fruit Compote, Cookies
12.	Sliced Bananas With Cream	Soft Cooked Eggs, Toast and Jam	Cream of Lettuce Soup	Thinly Sliced Ham, Apricot Sauce	Potato Patties With Cracker Crust	Sauté Parsnips	Canned Peaches, Lemon Cookies
13.	Tomato Juice	French Toast, Plum Jam	Peanut Butter Soup	All Vegetable Omelet		Cherry, Banana, Orange Salad	Bavarian Cream
14.	Apricot Nectar	Canadian Bacon and Apple Rings, Blueberry Muffins	Tomato Juice Cocktail	Spaghetti With Tiny Meat Balls	Frenched String Beans	Carrot and Raisin Salad	Rice Flake Macaroons, Hot Chocolate
15.	Pineapple Juice	Shirred Eggs, Toasted Rolls, Blackberry Jelly	Fruit Cocktail	Baked White Fish	Creamed Potatoes	Tomato Aspic Salad	Wine Syllabub
16.	Prune Juice	Jelly Omelet, Toast	Cream of Asparagus Soup	Graham Cracker Ham Loaf	Lemon Sweet Potatoes, Cranberry Relish	Jellied Fruit Salad	Lemon Snow, Custard Sauce
17.	Baked Apple	Soft Cooked Eggs, Raisin Toast	Chicken Broth With Celery	Creamed Sweetbreads on Toast		Salad Bowl of Mixed Vegetables	Ambrosia
18.	Half Grapefruit	Scrambled Eggs, Minced Bacon, Hot Muffins	Grape Juice	Escalloped Oysters	Creamed Diced Potatoes With Parsley	Tomato and Lettuce Salad	Apple Gingerbread Upside-Down Cake
19.	Canned Raspberries	Coddled Eggs, Hot Biscuits	Grape and Orange Cup	Broiled Lamb Chop	Baked Potato	Buttered Frozen Peas	Sponge Cake, Whipped Cream
20.	Stewed Prunes	Poached Egg on Rusk	Tomato Juice, Rye Krisp	Roast Beef, Gravy	Creamed Diced Turnips	Buttered Beets	Ice Cream, Nestle Cookies
21.	Sliced Bananas With Cream	Shirred Eggs, Muffins	Split Pea Soup	Asparagus on Toast, Egg Sauce	Baked Succotash	Pineapple and Cottage Cheese Salad	Cherry Dumpling
22.	Orange Juice	French Toast, Honey	Cream of Tomato Soup	Spaghetti and Cheese	Celery and Olives	Tossed Green Salad Bowl	Fruit Gelatin, Whipped Cream
23.	Half Grapefruit	Soft Cooked Eggs, Cornbread	Julienne Soup	Creamed Tuna and Peas on Toast	Buttered Diced Potatoes	Black Cherry and Pineapple Lemon Gelatin Salad	Mocha Custard
24.	Stewed Mixed Fruit	Bacon, Bran Muffins, Orange Marmalade	Corn Chowder	Noodles With Chicken Giblets		Stewed Tomatoes	Butterscotch Tarts
25.	Sliced Oranges	Scrambled Eggs, Hot Biscuits	Jellied Fruit Cocktail	Creamed Meat in Butterfly Shells	Baked Potato	Beet and Water Cress Salad, French Dressing	Lemon Snow, Custard Sauce
26.	Stewed Prunes	Jelly Omelet, Toast	Broiled Half Grape Fruit	Beefsteak Pie With Biscuit Crust	Buttered Lima Beans	Waldorf Salad	Eggnog Ice Cream
27.	Dried Fruit Compote	Bacon and Eggs, Gems	Cream of Asparagus Soup	Cheese Soufflé	Baking Powder Biscuits, Marmalade	Jellied Vegetable Salad	Prune Whip
28.	Stewed Raisins	Soft Cooked Eggs, Pop Overs	Fruit Cocktail	Creamed Chicken in Toasted Bread Cases	Buttered Asparagus	Tomato and Cottage Cheese Sandwich Salad	Angel Cake
29.	Tomato Juice	Shirred Eggs, Raisin Toast	Grape Juice	Panned Oysters	Au Gratin Potatoes	Baked Spinach	Peach Sauce, Cookies
30.	Orange Juice	Creamed Eggs on Toast, Jelly	Cream of Celery Soup	Roast Beef Hash	Broiled Half Tomato	Green Salad With Carrot Slivers	Ice Cream and Cake
31.	Grapefruit Juice	Creamed Fish Flakes on Toast	Tomato Juice, Rye Krisp	Baked Lamb Patties	Buttered Beets, Braised Whole Carrots	Orange and Onion Salad	Chocolate Pudding, Whipped Cream

Recipes will be supplied on request by Anna E. Boller, The Modern Hospital, Chicago. Space precludes listing of cereals, several varieties of which are always offered for breakfast.

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ANALYSIS IN GRAMS

Based on 30 grams *Dry* Ralston

	GRAMS
Fat	.51
Protein	4.5
Carbohydrates	21.0
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Iron	.0012
Calcium	.015
Phosphorus	.12
Manganese	.0012
Copper	.00018

106 Calories

30 grams Ralston Wheat Cereal contain 45 International Units vitamin B_1. Ralston is a rich source of vitamin E and a good source of vitamin G.

Choice of Barbiturates

HORATIO C. WOOD JR., M.D.

APPROXIMATELY 20 narcotics that are derivatives of the compound commonly called barbituric acid are now on the market. There is obviously no medical necessity for so many drugs closely related to one another physiologically as well as chemically and it would be wasteful to stock all of them in the hospital pharmacy. It may, therefore, be worth while to discuss briefly some of the more important pharmacologic and clinical facts concerning this group with a view to eliminating superfluous encumbrances from the shelf and the budget.

In the first place, attention may be called to the close similarity in chemical structure. Malonyl urea (more commonly called barbituric acid) has two hydrogen atoms that can be replaced by various hydrocarbons. If both of these hydrogens are replaced by the ethyl radical the result is diethylmalonylurea, or barbital; if one is replaced by ethyl and the other by pentane, the result is pentobarbital. The only difference between the barbiturates is in the groups that replace the hydrogen.

These compounds are as much alike in their physiologic action as they are in their structure; the only differences between their effects are in degree. In small doses all of them lessen intellectual excitability and are, therefore, useful to quiet nervous unrest; in somewhat larger amounts they cause a hypnosis practically equivalent to normal sleep, and in large doses give rise to complete coma with apparent loss of all sensibility. In fatal doses the chief cause of death is the failure of respiration, although the blood pressure is considerably lowered.

In the early days of the barbituric acid era, an attempt was made to find a basis for choice among the compounds in their relative toxicity. The actual quantity required to produce a desired effect, such as sleep, or to cause death is not a matter of great moment. The important factor is the ratio between the hypnotic and lethal doses, or what is often spoken of as the therapeutic index. There are, however, certain technical difficulties in the way of determining these figures that render accurate judgment as to the comparative safety of the various barbiturates practically impossible.

Wholesale Prices of Commercial Preparations

Drug	*Size of Tablets*	*Cost per 100*
Alurate	1 gr.	$2.20
Amytal	1½ gr.	2.10
Dial	1½ gr.	4.00
Evipal	4 gr.	3.13
Ipral-Calcium	2 gr.	3.18
Ipral-Sodium	2 gr.	2.55
Luminal-Sodium	1½ gr.	2.50
Mebaral	3 gr.	2.00
Neonal	1½ gr.	1.64
Pentobarbital	1½ gr.	3.39
Pernoston	.....	5.00
Sandoptal	.....	6.20
Seconal	1½ gr.	3.10
Veronal-Sodium	5 gr.	3.60

In the first place, determination of the depth of narcosis in animals is so impracticable that only inexact figures can be expected; second, there is wide variation in the relative susceptibilities of different species of animals to different members of the barbiturate family, and it is only to be presumed that there may be as marked a species difference in human beings; third, the variations in therapeutic indices are, after all, relatively small.

Despite considerable experimentation along this line the best that can be said is that amytal, dial, pentobarbital, seconal and phanodorn have relatively safe therapeutic indices, while alurate, ipral, barbital and phenobarbital are all more dangerous. After all, the leeway between the hypnotic and lethal dose for human beings is so wide that the question is of importance only when these drugs are used for other purposes in which very large quantities are required.

A difference of much more practical importance between the various barbiturates is their mode of elimination. Some of them, such as evipal, are almost completely destroyed in the liver and no trace of them is ordinarily discoverable in the urine after their administration; on the other hand, after the administration of barbital practically all of it may be recovered from the urine. The kidney excretion of these drugs is comparatively slow so that those that are eliminated solely by this channel remain in the system for many hours, whereas destruction by the liver is rapid and the drug disappears from the blood in a few minutes. For this reason there is a wide variation in the duration of their effects.

Between the two extremes quoted there are all degrees of hepatic destructibility. Some may be 80 per cent destroyed and 20 per cent excreted and others, 20 per cent destroyed and 80 per cent excreted so that the permanence of action is about as follows: *very transient,* evipal and pentothal (strictly speaking pentothal is not a barbiturate but a thiobarbiturate, since the oxygen of the malonyl urea has been replaced by sulfur); *transient,* seconal, ortal, phanodorn, pentobarbital (also known as nembutal), amytal and sandoptal; *persistent,* nostal, alurate, dial, ipral and neonal; *very persistent,* barbital and phenobarbital.

From the standpoint of practical therapeutics, the difference in rate of action is of fundamental importance. It must be remembered that although these drugs were originally introduced as sleep promoters, they are at present used as depressants to the

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nervous system for a wide variety of purposes. These uses may be classified as follows: (1) somnifacients, (2) euphorics in states of nervous excitability, (3) remedy for acute convulsions (such as strychnine or cocaine poisoning), (4) remedy for epilepsy, (5) adjuvant analgesics and (6) surgical anesthetics. A drug like phenobarbital, the effects of which last for many hours, is of great value in epilepsy in which the motor system must be kept in a state of lowered activity. In strychnine poisoning, in which the patient's fate is usually settled in less than an hour, however, it is almost worthless. A complete barbituric service would seem to demand at least three types of drugs: a very rapid, a very slow and an intermediate.

The relative cost of these drugs is a problem that is of special interest in hospital practice. The mere fact that a drug is expensive does not prohibit its use in a hospital, yet, when two substances are equally efficient for the same remedial action, preference will naturally be given to the less expensive. In comparing the costs, we should take into account not merely the price per ounce but the price per dose. The accompanying table shows the wholesale price per hundred tablets of the size recommended by manufacturers in 1938.

Pharmacy Is Pride of Hospital

"WHERE to start?" is a question new hospital superintendents must inevitably ask themselves, according to Anthony W. Eckert, superintendent of Fitkin Memorial Hospital, Neptune, N. J., who completed his second year as administrator of the institution in January.

Mr. Eckert began by going over the plant from top to bottom and was faced with the usual necessity for painting and remodeling certain departments on an extremely limited budget. His idea was that "he who travels a thousand miles must first take one step" and the first step was the drug room.

Previously, the drug room had been composed chiefly of a vast collection of bottles on open shelves, packing cases and hogsheads. The department, nevertheless, was efficiently run by Alfred Gidlund, hospital pharmacist, despite its appearance and inconvenience.

The renovation of the drug room, shown in the accompanying before and after pictures, was accomplished at small cost. Doors were placed on all shelves which converted them into 16 up-to-date cabinets, with the contents listed on the back of each door.

Under the new arrangement the work table, materials and medicines used in dispensing the drugs are behind a partition that hides unsightly material.

The pharmacist is employed on a full-time basis and he has charge of filling all floor requisitions for drugs and medical supplies. He makes out all charge slips for drugs to be charged to patients and keeps an accurate drug inventory. Because of his knowledge of drugs and supplies, he also renders an important service in assisting with the purchasing.

The pharmacist cuts the gauze that is given to the various auxiliaries for their work in making surgical supplies. Furthermore, he makes minor repairs on all surgical equipment. This is quite aside from making daily prescriptions and preparing mouth wash solutions, Burow's solutions, aromatic spirits of ammonia, rhubarb and soda and other compounds.

He also has control of the oxygen and other gases used in the hospital, as well as of alcohol and liquor dispensed to the floors. No one, of course, has access to the drug room except the pharmacist, the superintendent, the director of nursing and her assistants.

The drug room is open every day from 9 a.m. to 5:30 p.m. to fill emergency orders, although regular requisitions from the floors are filled three times a week as a routine.

Mr. Eckert is particularly proud of the new pharmacy and when he takes visitors on tours of the hospital he usually starts where he himself started—at the drug room.

BEFORE: A heterogeneous array of boxes and bottles confronted the visitor to the pharmacy before the remodeling process was begun.

AFTER: Doors placed on the open shelves converted them into neat cabinets. The contents of each are listed on the back of the door.

NOTES AND ABSTRACTS

By Carl C. Pfeiffer, M.D., Department of Pharmacology
University of Chicago

What Causes Headache?

It has been found that a large proportion of the cranial contents is entirely without sensation. Cutting, burning or otherwise traumatizing the gray matter does not give rise to any sensation. The region of the dura mater near the larger vessels is pain sensitive, however, and trauma in this region does give rise to pain sensation. The supporting membranes, namely, the falx cerebri and the tentorium cerebelli, are also sensitive to stretch stimulation, although most of the dura is insensitive. These pain sensations are mediated by the fifth cranial nerve, as has been demonstrated in cases of brain operations on trigeminal neurectomized patients.

In order to study the changes that take place during headache, it is necessary to be able to produce headache experimentally under controlled conditions. Several methods have been used to produce experimental headache. Among them are: histamine injections, nitrite administration, carbon monoxide inhalation and lumbar puncture.

Histamine Headache

• In 1933 Pickering made one of the earliest specific studies of the headache caused by histamine. His work was followed by that of Clark, Hough and Wolff in 1934. These men correlated changes in blood pressure, cerebrospinal fluid pressure and intracranial pulsations with the intensity of the headache so produced.

Headache is readily brought on with histamine by the intravenous injection of 0.1 mg. of the acid phosphate. The first symptom is a metallic taste, followed by the appearance of headache about one minute after the injection. This headache begins frontally on both sides of the head and then gradually extends toward the vertex and may go as far as the occiput. Then, as the headache decreases in intensity, it gradually regresses and finally disappears within from six to ten minutes after the injection. Immediately after the injection there are a rise in cerebrospinal fluid pressure and a fall in blood pressure, but these are almost back to normal by the time the headache appears. However, as the blood pressure and cerebrospinal fluid pressure return to normal, there is a rise in the amplitude of intracranial pulsations to about twice the normal height. This pulsation returns to normal as the headache disappears.

In order to prove that the headache was a result of the changes following histamine, and not to toxic effects of histamine alone, histamine was infused into experimental subjects at rates up to 1 mg. per minute. It was found that the same changes in blood and cerebrospinal fluid pressure took place but that the headache did not occur until one minute after the infusion was stopped. It was also found that a second injection would give prompt relief of a headache caused by a previous histamine injection but that the headache would return after a minute had elapsed. A histamine injection would also cause a spontaneous headache to disappear for one minute, showing that the mechanism of the two is somewhat the same.

Relief could be obtained from this headache by several means, it was found. Vasodilation by amyl nitrite would give temporary relief, as would increasing intracranial pressure by the injection of normal saline solution into the subarachnoid space, by jugular compression or by lowering the head. Reducing arterial pressure by forced inspiration with closed glottis (Müller's experiment) or by compressing the carotid on one side would give temporary relief.

Shaking the head aggravated the pain, much as it does in spontaneous headache. This presumably put increased strain on the pain sensitive structures. Removal of cerebrospinal fluid also intensified the pain, and it was found that, after the removal, compression of the jugular veins increased the pain rather than lessened it. Anything that increased the arterial pressure alone would increase the intensity. Forced expiration of closed glottis (Valsalva's experiment), if performed suddenly, would increase the intensity, although if the experiment was prolonged, the headache would be diminished.

Blocking the flow of blood in the superficial arteries of the scalp before the injection of histamine had no effect on the appearance of the headache, and since shaking the head did increase the intensity, it was concluded that the headache arose in some structure inside the cranial cavity that could be strained by movements of the cranial contents. Since it has been shown that pain receptors are present only near the larger dural vessels, it was concluded that the headache following histamine injection arose near these vessels. It was also found in cases of trigeminal nerve section that headache could be produced on the normal side and not on the neurectomized side.

The mechanism for this headache was thought to be a result of relaxed vessel walls with abnormal stretching when blood pressure became normal.

Nitrite Headache

• In 1927 Leake, Loevenhart and Muehlberger studied the changes that take place during the headache produced by application of glyceryl trinitrate to the skin. This is so familiar to ammunition workers that they frequently carry some nitrite in their hatbands so that they will not lose their tolerance over week ends. It was found that 15 gm. of this substance would produce severe headache, with accompanying dilation of the retinal vessels. This was probably accompanied by cerebral vessel dilation, for Hirschfelder has shown by experimenting on cats that cerebral dilation and retinal dilation are comparable.

This headache was probably due to the intense vasodilation caused by the nitrite.

Carbon Monoxide Headache

• The rôle of carbon monoxide inhalation in the production of headache was studied by Forbes, Cobb and Fremont-Smith. Working on an experimental subject, they found that the headache did not come on until about half an hour after the inhalation was stopped and that it appeared when there were no other toxic symptoms.

In an experimental animal, inhalation of carbon monoxide caused increased intracranial pressure, which was probably due both to cerebral edema and to cerebral congestion from increased arterial pressure. These men came to the conclusion that the headache was closely associated with the increased intracranial pressure.

Lumbar Puncture Headache

• Headache occurs following lumbar puncture in from 5 to 20 per cent of all cases. This headache is accompanied by a fall in cerebrospinal fluid pressure, which may result from loss of cerebrospinal fluid through the puncture wound in the dura into the extradural space, since it has been shown that, if the hole is blocked, there is a reduced incidence of postlumbar puncture headache. This headache differs from histamine headache in that compression of the jugular veins causes increase in intensity of the pain. The postlumbar puncture headache may arise from increased pressure of the brain on the dura surrounding the foramen magnum, owing to the lowered cerebrospinal fluid pressure.

This Plan Cuts Linen Losses

JACK G. CHARLE

TWO basic systems of linen control are used by hospitals, namely, the exchange and the requisition methods. These may vary considerably in their application according to the size and specific conditions of the institution.

The requisition system seems to be the simpler of the two since it necessitates a minimum of stock and employes. Sometimes, however, it is possible to combine certain features of both methods as has been done in Beth-El Hospital, Brooklyn, N. Y. It is not the intention to claim a singular success for this method of eliminating linen losses. We admit that some linens are still being lost, and in all probability some losses will continue. We have, however, succeeded in tracing various sources of loss by instituting certain control methods that have been evolved from an understanding between the nursing department and the housekeeping department.

Beth-El has two main divisions, a 142 bed general hospital and a 70 bed maternity hospital. The linen stock is adequate and is based on a three and a half set complement per bed. Each set consists of two sheets, two pillow cases, two draw sheets, one bedspread, one gown, one bath towel and one face towel. Various smaller items, such as hot water bag and bedpan covers and scarves, are supplied according to the needs of each separate room or ward.

All linens are marked with the hospital's name, the date of issuance and the name of the ward. The argument that is most often used against the system of marking the linen separately and keeping a maximum inventory is that since each ward or room is required to keep stock of at least three changes, plus emergency changes, there is always a surplus of stock lying idle in the closet because the occupancy is not always complete. What the exponents of this argument forget is that the total linen stock must equal the number of beds whether the linen is marked separately or not and that there is often a 100 per cent occupancy at which time every bed's linen must be on hand. All linen is marked as to floor and each floor is provided with adequate storage space. The excess linen for each floor is stored in a linen room located in the laundry. Sufficient linen for the daily bed requirement is sent to each floor.

The author is in charge of maintenance at the Beth-El Hospital, Brooklyn, N. Y.

Linen Standard per Bed

To avoid unnecessary red tape, linen requisitions are not made out by the nursing department but by the housekeeping department, which makes a daily inspection of all linen closets and requisitions linen for each ward according to a standard per bed based on the census of patients in each ward and on the linen supply still remaining in the closets. All linen requisitions are made out in duplicate on laundry lists. The original accompanies the clean linen that is received on the floor and the copy is filed in a ledger kept in the hospital laundry.

This ledger is a daily, as well as a monthly, record for each floor's linen usage and forms the basis for a monthly survey for the daily laundry production, since every piece of linen that leaves the laundry is thus entered and totaled in this ledger. Only four hospital departments are not controlled by this method.

The operating and delivery rooms keep their entire linen stock on their own shelves. No standard can be set up for their use because their daily needs show too great a variation. All linens from these departments are returned to them without question.

In a like manner the food service department is the sole manager of its linens. A central linen storeroom is provided for the nurseries in the maternity building where all linen is autoclaved and placed in packs before it is sent to the nursery. This is the only department in which the nurses fill out requisitions, although these, too, are checked according to census by the attendant in charge of this room.

The employes' personal linen is limited and certain days are set aside for collection and delivery. All employes' laundry bags must be accompanied by laundry books showing the name, laundry number, location and a complete list of articles. Failure to include such a book disqualifies the employe from receiving service.

Such a control system must concern itself with ways and means of preserving the life and appearance of the stock and to that end it is necessary to understand the causes of linen shrinkage. None of the methods of control now in use has been completely successful in obviating linen loss. The causes of linen loss, however, may be divided into three groups: careless handling, stains and incorrect washing methods.

In an article entitled "What Causes Linen Loss?" that appeared in the September issue of the The Modern Hospital, I pointed out that much of the shrinkage can be explained by the neglect and carelessness of the hospital personnel. While some employes can be educated to the point of exercising the proper care in handling linen on their own initiative, many of them must be made to adhere to stipulated rules and regulations. The following excerpt from the nurses' manual of Beth-El Hospital sets forth the rules that have been set up for the care of linen. The nurses are asked to cooperate in enforcing these rules.

Linen

1. The list that accompanies the laundry must be checked and a slip turned into the nursing department.

2. Gowns or other linens are not to be worn by nurses.

3. Linen must not be torn or cut. If it is absolutely necessary, permission must be obtained from the supervisor. Remove the patient's arm from the gown before giving an intravenous injection.

4. Requisitions for new linen are to be sent to the nursing office.

Stained Linen

1. A bundle of old linen is to be kept on each ward.

2. Notify the housekeeper or send a note to the laundry foreman for a supply of old linen. Old linen must be used for cases in which gentian violet, ichthyol, methylene blue and balsam of Peru are used.

Blankets

1. Send a slip to the housekeeper for additional blankets before 10 a.m. so that they may be delivered with the afternoon laundry.

2. The night reserve supply is in 2A cupboard. A slip must be left for the number taken.

3. Only white cotton blankets are to be used for stretchers.

4. Extra blankets used at night are to be folded and returned to the closet.

Old Linen for Cleaning

1. There are two supply bags in the utility room: one for clean rags and one for soiled rags. Use them for general cleaning.

2. Clean rags may be obtained from the seamstress.

3. Soiled rags are to be given to the washer. Towels and scarves are not made for cleaning.

Binders

1. Slips are to be made out for scultetus and breast binders, showing date, name of patient, name of nurse and location of patient.

2. A slip is to be given to the gauze room attendant in exchange for a binder.

3. Soiled binders may be exchanged for clean ones as necessary.

4. After the binder has been discontinued, return it to the gauze room and exchange it for the original slip. You are responsible.

Living Quarters

1. Linens, such as towels, scarves, sheets and blankets, are not to be taken from departments for use in the nurses' home.

2. In the event that linen is torn or burned, please notify the nursing office at once by sending a slip with the name of article and the damage done. This will facilitate matters greatly.

The points covered in this excerpt relate to the first two causes of linen loss. The third group is distinctly the affair of the laundry department. The laundry manager or foreman is expected to know his business. Nevertheless, slip-ups have been known to occur and damage has resulted from incorrect methods of washing. Frequently this is the result of overbleaching or faulty loading of extractors. Either one will shorten the lifetime of linens.

THE HOUSEKEEPER'S CORNER

• Decoration, the importance of dress for the woman executive and linen control were the subjects featured on the Women's Day Program of the twenty-fourth National Hotel Exposition, held recently in New York. The program, under the auspices of the New York chapter of the National Executive Housekeepers Association, included addresses by Mrs. Doris Dungan, national president of the N.E.H.A., Mrs. Jessie M. Finney, president of the New York chapter, Mrs. Margaret Connelly, program chairman for the day, Edward B. Bell, general chairman of the Hotel Exposition, Carl Willmsen, retiring president of the New York State Hotel Association and Charles Wicks, incoming president.

Mr. Bell remarked that his hotel places brown wrapping paper and string in hotel rooms for departing guests to use in wrapping shoes or soiled clothes; this materially cuts their linen loss. In addition to this procedure, an admonition as to the guest's responsibility to the hotel and a careful system of linen control reduced the loss on hand towels from 3431 in 1936 to 1426 in 1938 and on large sheets from 190 to 3 in the same period.

Maude Boulden of *Commercial Interiors,* formerly a hotel housekeeper, discussed practical decorating in hotels; Kay Hardy, director of the American School of Design, spoke on the importance of dress for the woman executive, illustrating how to choose lines in clothes that will make the tall woman look less tall and the short woman taller. Blanche Smiley and Helen Park of *Decoration Maintenance* conducted a sprightly decoration clinic, explaining their approach to the hotel decoration problem and illustrating their comments with sample color schemes and upholstery fabrics attractively displayed. Myrtle Stevens, executive housekeeper of Hotel Delmonico, New York, requires maids and bus boys to sign for every piece of linen removed from the linen room, thus making each of them personally responsible for the amount she or he distributes.

• If you want to save time and effort in cleaning painted walls, here is a method that Bernice Stein, executive housekeeper of Presbyterian Hospital, Chicago, heartily recommends: Boil a handful of ordinary laundry starch in half a bucket of water, and add a handful of soap powder or washing soda. The fluid is applied with a whitewash brush and rinsed off. The starch thickens the water so that it is not so likely to drip and at the same time holds the solution against the wall long enough to permit it to work effectively.

• Each maid at Mountainside Hospital, Montclair, N. J., fills out a slip when she finishes cleaning a room. "The following empty room cleaned, ready for inspection," it reads. She signs her name and leaves it in the office of Mildred L. Burt, the executive housekeeper. Immediately Miss Burt or her assistant goes to the room and inspects it thoroughly. "Where we note that something is not as it should be," Miss Burt explains, "we immediately get the maid and ask her to correct it. We are not likely to find the same fault occurring a second time, as far as that maid is concerned."

This plan gives the housekeeper control over the cleaning of rooms and enables her to make a detailed inspection, including window shades, walls and woodwork. In the event that she finds the walls in bad condition, for example, it is possible for her to arrange to get the painters and washers on the job before the next patient arrives. The person who makes the inspection also signs the slip.

• One who has experience with shade cloth material indicates that duck is the most economical material for use over a period of years. It has the advantage that it does not fray at the edges. The cloth can be removed from the roll, washed, mangled and replaced. Duck, also, does not tear as easily as some types of shade cloth that are particularly likely to tear after being exposed to the sun for a few years.

Monthly News Review

Vol. 54 February 1940 No. 2

Federal Program in Regard to Hospitals Rapidly Changing, Conference Indicates

So far as President Roosevelt is concerned both the Wagner Bill and the National Health Program are dead issues, it is reliably reported.

Moreover, the President's proposal of December 21 (see editorial on page 49) regarding the use of federal funds for the construction of "small" hospitals of 100 beds will probably be modified following a conference between federal officials and representatives of hospitals and the medical profession.

On invitation from the President, representatives of the American, Catholic and Protestant hospital associations and of the American Medical Association met in Washington January 10 to discuss his construction plan for small hospitals. Surgeon General Thomas Parran and Dr. Joseph Mountin of the U. S. Public Health Service and Surgeon General Ross McIntire of the Naval Medical Corps were in attendance.

Representatives of the hospitals and of the medical profession met in advance of the conference and agreed on a memorandum which was left with the President. The memorandum is as follows:

"1. Hospitals to be built where need for same can be shown. Advisory consultation in the determination of such need to be given by the state medical and hospital associations, the state health department and the county judges or officials of the counties in which such hospital services are proposed.

"2. Size of hospital to be commensurate with the needs of the community and the ability of the latter to support it.

"3. Means for the maintenance and upkeep of such hospitals rank in importance equal to that of construction.

"4. Since the important objective of the program is the service it can render, hospital construction and administration, equipment, staff and personnel should meet the standards which the American Medical Association, the American College of Surgeons and the hospital associations regard as minimal for rendering such service in the various localities. Where needed, since highly specialized facilities and personnel cannot be made available in all places, affiliation with larger hospitals or hospital centers to be had to the end that highly specialized services for diagnosis and treatment be made available to all.

"5. Maintenance of a standard of professional and hospital service that will keep it efficient and prove attractive to qualified men and women as a career.

"6. Utilization of existing facilities where possible: Under no circumstances should the program be allowed to develop into competition with the voluntary hospitals but should rather foster cooperation between the two groups.

"7. Many small communities can be better served by the utilization of bed vacancies in available existing institutions than by the construction of new hospitals, transportation and per diem expense to be borne by state and/or county funds. Where state and/or county funds cannot be provided, expense to be met by, and to be dispensed by, local agencies.

"Ambulance service and good roads will permit this type of service to operate safely, efficiently and economically in communities not financially able to support a hospital."

Dr. Fred G. Carter, Dr. Bert Caldwell, Monsignor Griffin, Father Schwitalla and the Rev. Paul R. Zwilling represented the hospital associations at the conference.

Representing the A.M.A. were Drs. Irvin Abel, Walter F. Donaldson, Frederic Sondern, Walter E. Vest, Fred W. Rankin, Edward H. Cary, Austin A. Hayden, Olin West, R. G. Leland and W. D. Cutter.

Sanatorium Bonds Authorized

No federal funds being available, the freeholders of New Providence Township, Union County, New Jersey, have authorized a bond issue to erect a $100,000 addition to Bonnie Burn Sanatorium, Scotch Plains, N. J. A three story wing will be built which will house the x-ray department and additional accommodations for patients.

Government Selects Thirteen Hospitals for Radium Supply Loans

The U. S. Public Health Service has made public the names of the 13 hospitals that will receive government-owned radium on a loan basis. The radium, weighing about 2 grams, is now being tested by the Bureau of Standards. It will be shipped in small platinum irridium needles, tubes and cells imbedded in lead containers.

The Ellis Fischel Hospital, Columbia, Mo., now nearing completion for the Missouri Cancer Commission, will receive one consignment. Other recipients are: El Paso City-County Hospital, El Paso, Tex.; Baylor University Hospital, Dallas, Tex.; Hillman Hospital, Birmingham, Ala.; St. Joseph's Infirmary, Louisville, Ky.; Robert Winship Clinic of Emory University, Emory, Ga.; Greenville General Hospital, Greenville, S. C.; Tri-County Hospital, Orangeburg, S. C.; Broadlawns, Polk County Public Hospital, Des Moines, Iowa; Indianapolis City Hospital, Indianapolis; University Hospital System of Pittsburgh Hospital, Pittsburgh; New Britain General Hospital, New Britain, and Receiving Hospital, Detroit.

Under the terms of the loan institutions may make no charges to patients for use of the radium. Choice of recipients was made on the bases of need for radium, competence of staff and adequacy of facilities for radium treatment.

Authorities hold that there should be 2 grams of radium for every million citizens. Less than 200 grams are in use in this country at the present time. Radium can be used over and over again for thousands of years.

Lectures for Library Volunteers

During February and March a number of New York Junior Leaguers will spend two mornings a week in a training course for hospital library volunteers. The course, being conducted by the Central Bureau for Hospital Libraries, consists of 13 lectures and several field trips. A $5 fee covers the expenses of the course. At a tea on March 21, certificates will be awarded to those young women completing the course.

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Voluntary Hospitals Are Pioneers in Improvements in Service: Goldwater

The principal improvements in hospital service in the past twenty or thirty years have, in most instances, been pioneered by the voluntary hospitals and then followed by governmental institutions, declared Dr. S. S. Goldwater, commissioner of hospitals of New York City, speaking before the fourth annual meeting of the Chicago Hospital Council on January 15.

Doctor Goldwater outlined six lines of improvement as typical of all advances in hospital service. In each instance he showed how the principal pioneering work was done by voluntary hospitals. The lines of advance were: (1) follow-up service through medical social workers, (2) convalescent care, (3) laboratory development, (4) refinements in patient care through such matters as adequate nursing service, (5) appointment systems in outpatient departments and reduction in overcrowding, (6) recognition of the place in general medicine and, therefore, in general hospitals of psychiatry.

"The voluntary hospital, with its flexibility, its freedom of action, its budgetary elasticity, is in a position of primary importance in introducing progress in public medicine," Doctor Goldwater declared.

He then listed some of the defects of voluntary hospitals. Among others, he noted lack of coordination of efforts among voluntary hospitals themselves, limitations to special religious, racial, age or other groups, and exclusion of chronic disease patients.

The preservation of voluntary hospitals will depend, Doctor Goldwater declared, in considerable part upon whether hospital service plans can be developed that will reclaim for the voluntary hospitals all patients who are not "definitely and irretrievably in the indigent class." With the advice and help of the medical profession, vigorous efforts must be made to bring all regularly employed persons back into the group that patronizes the voluntary hospital, he stated. He praised hospital care insurance plans for the work done but expressed regret that they were begun at too high an economic level.

Campaigns for Funds

Middlesex General Hospital, New Brunswick, N. J., is conducting a campaign for $200,000 with which to build and equip a nurses' home. The building would house 90 staff and student nurses, for a part of the plan is to establish a school of nursing.

Olson Heads Hawaiian Group

G. W. Olson, superintendent of Queen's Hospital, Honolulu, T. H., was elected president of the Hospital Association of Hawaii at the association's first meeting. Twenty-five hospitals out of a possible 40 were represented at this organization meeting. The association adopted the model bylaws of the American Hospital Association. A conference of the new association will be held in conjunction with the Territorial Nurses' Association meeting in April or May.

Wheeler Takes New Post

Leon R. Wheeler is the new executive secretary of the Associated Hospital Service, Inc., of Wisconsin, with headquarters in Milwaukee. Mr. Wheeler was formerly connected with the Rochester Hospital Service Association, Rochester, N. Y.

To Discuss Community Nursing

The Central Council for Nursing Education will hold its annual meeting and luncheon on February 12 at the Palmer House, Chicago. Elizabeth Fox, R.N., executive director of the New Haven Visiting Nurse Association and associate professor of the Yale School of Nursing, is to speak on "A Plan for Meeting the Nursing Needs in the Community." This subject will be the third in a series of five programs on community nursing needs.

Campaign for Accident Quarters

Funds to build and equip a new accident and emergency department for Roosevelt Hospital, New York, are being sought. The goal is $125,000. Business concerns and corporations in the district are asked to contribute.

Donates Site for Hospital

A 24 acre site has been donated for the proposed $400,000 hospital at Lake Forest, Ill., a north shore suburb of Chicago. Mrs. Albert B. Dick Sr., widow of the mimeograph manufacturer, has given part of her estate as the hospital site. Funds for the hospital have been accumulating for several years. The Alice Home Hospital will be part of the new institution when it is completed. Anderson and Tichnor, Lake Forest architects, are at work on plans for the building.

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If yours is famed *tomorrow*, it will be because you *kept* it so with a kind of man and woman that your community will like and love and trust.

These things *you have told to us* for as long as we remember . . . that all the things you do, and all the fame that's yours, are *good* or *never worth the telling*, depending on the personnel that's yours.

Then, won't you make it *fine*, make sure that every man and woman . . . . . has a chin that tilts; has eyes that challenge every difficulty, has nimble, skillful fingers; has wisdom, understanding, sympathy; and eager intent, and comfortable, pleasant ways?

Then you'd grow great in famed things done, as though some gentle mother with all your skills had taken your community to heart.

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Canada Refutes Tale of Interned Exhibitor at A.H.A. Convention

Rumors that a representative of an American firm exhibiting at the A.H.A. convention in Toronto last September has been interned for the duration of the war have been investigated by Dr. G. Harvey Agnew, retiring president of the association and secretary-treasurer of the Canadian Hospital Council.

The director of immigration for Canada states that this story is absolutely false. Immigration officers have no power of internment, he declares.

The story, which has probably had wide circulation, according to Doctor Agnew, is that one firm's representative at the convention told the immigration officer that he had been born in Germany and, being unable to claim United States citizenship although he had resided in the United States for twenty-six years, he was listed as an enemy alien, refused permission to return to the United States.

"The Canadian government is making every effort to facilitate the entry of bona fide Americans into Canada at any time," Doctor Agnew states, "as there is a strong desire to maintain the closest friendly relations between the two countries."

Cancer Cases Now Reportable

Every hospital in upstate New York is now reporting cases of cancer to the district health officer or to the city or county health officer. Physicians and laboratories also are required to report cancer cases, under a new law that became effective January 1. This legislation is designed to make available accurate information instead of uncertain estimates regarding the occurrence of cancer in that region.

Coming Meetings

Feb. 2-3—Arizona Hospital Association, Phoenix.
Feb. 12-13—Council on Medical Education and Hospitals, American Medical Association, midwinter meetings, Palmer House, Chicago.
Feb. 13-15—National Methodist Hospitals, Homes and Deaconess Work Association, Hotel Morrison, Chicago.
Feb. 22-24—Texas Hospital Association, San Antonio.
March 6—Massachusetts Hospital Association, Hotel Statler, Boston.
March 7-9—New England Hospital Association, Hotel Statler, Boston.
March 27—Mississippi State Hospital Association, Edgewater Gulf, Biloxi, Miss.
March 27—Nebraska Hospital Assembly, Hotel Cornhusker, Lincoln.
March 28-30—Southeastern Hospital Conference, Edgewater Gulf, Biloxi, Miss.
April 2-4—Ohio Hospital Association, Columbus.
April 4-6—Carolinas-Virginias Hospital Conference, Winston-Salem, N. C.
April 8—Tennessee Hospital Association, Chattanooga.
April 8-11—Association of Western Hospitals, Hotel Biltmore, Los Angeles.
April 11-12—Mid-West Hospital Association, Kansas City, Mo.
April 17—Alabama Hospital Association, Birmingham.
April 22-24—Iowa Hospital Association.
April 25-26—Kentucky Hospital Association, Brown Hotel, Louisville.
May—South Dakota Hospital Association, Sioux Falls, S. D.
May 1-3—Tri-State Hospital Assembly, Hotel Stevens, Chicago.
May 8-10—Hospital Association of Pennsylvania, William Penn Hotel, Pittsburgh.
May 16-17—Kansas State Hospital Association, Hotel Allis, Wichita.
May 18—Washington State Hospital Association, Spokane, Wash.
May 22-24—Hospital Association of the State of New York, Buffalo.
May 23-25—Minnesota Hospital Association, Minneapolis.
June 6-8—New Jersey Hospital Association, Atlantic City.
June 17-21—Catholic Hospital Association, Municipal Auditorium, St. Louis.
July 28-Aug. 10—Southern Institute for Hospital Administrators, Duke University, Durham, N. C.
Aug. 11-13—National Hospital Association, Houston, Tex.
Aug. 11-24—Western Institute for Hospital Administrators, Stanford University, Stanford University, Calif.
Sept. 1-15—American Hospital Association Institute for Hospital Administrators, University of Chicago.
Sept. 1-15—New England Institute for Hospital Administrators, Harvard Medical School, Cambridge, Mass.
Sept. 2-7—American Congress of Physical Therapy, Hotel Statler, Cleveland.
Sept. 14-15—American Protestant Hospital Association, Boston.
Sept. 15-16—American College of Hospital Administrators, Hotel Statler, Boston.
Sept. 16-20—American Hospital Association, Hotel Statler, Boston.
Oct. 20-24—American Dietetic Association, Hotel Pennsylvania, New York.
Nov. 13—Colorado Hospital Association, Denver.
Dec. 5—Utah State Hospital Association, Salt Lake City.

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Hospitals Held Responsible for Injuries Received by Their Patients

The supreme court of California on December 28 reversed the previous decisions of the courts of that state and held that voluntary hospitals are responsible for injuries received by patients. Judgments of $2250 against the Good Samaritan Hospital of Los Angeles and $3000 against Providence Hospital, Oakland, were affirmed.

In his decision for the court, Justice Douglas L. Edmonds declared that "the hospital is rarely maintained upon the donation of one charitably disposed individual. This is a business enterprise which, although it may be the recipient of some donations, is able to carry on its work because the aggregate amount received from paying patients is sufficient to meet the expense of administration to those patients and also to others accepted at a reduced rate or without charge."

The case against the Good Samaritan Hospital was brought by Charles E. England as a result of burns from a hot water bottle and that against Providence Hospital resulted when Mrs. Elizabeth Silva, 74, broke her leg when she fell out of a bed on which sideboards had not been placed.

Justice John W. Shenk filed a dissenting opinion in which he declared that the true test of a hospital's charitable status should be the general nature of the institution, even though it does realize a profit from the care given to certain individuals.

The American Hospital Association had advanced $300 to help meet the legal expenses in the case of England *v.* Good Samaritan Hospital.

Westinghouse Takes Out Hospitalization Policy With Equitable Life

The Westinghouse Electric and Manufacturing Company of East Pittsburgh, Pa., recently announced that hospitalization insurance had been taken out by the company with the Equitable Life Assurance Society for employes at the head office, seven district offices and six other divisions.

At certain locations employes have expressed a preference for local hospital care plans and, when the unit was sufficiently large and when mutually satisfactory arrangements could be made, the company has cooperated in providing care under such plans.

The Equitable plan costs 60 cents per month for the employed person and $1.35 for all dependents regardless of number. Benefits are $4 a day for employes and $3 for dependents. Twenty dollars is allowed to employes for special charges and $15, to dependents. Dependents must wait three months before being eligible for another hospital stay.

Philadelphia Will Have Hospital for Convalescents

The needy and unemployed patients of the general hospitals of Philadelphia are to have a special hospital in which to convalesce, through a $600,000 endowment left by Anna J. Magee, who died in 1923. A 70 to 100 bed hospital will be built on a 15 acre tract overlooking Fairmount Park and the Wissahickon Valley. Children under 14 and patients suffering from communicable or incurable diseases will be excluded.

The institution will be known as the Magee Memorial Hospital for Convalescents and is intended to relieve the general hospitals of the burden of indigent convalescent patients.

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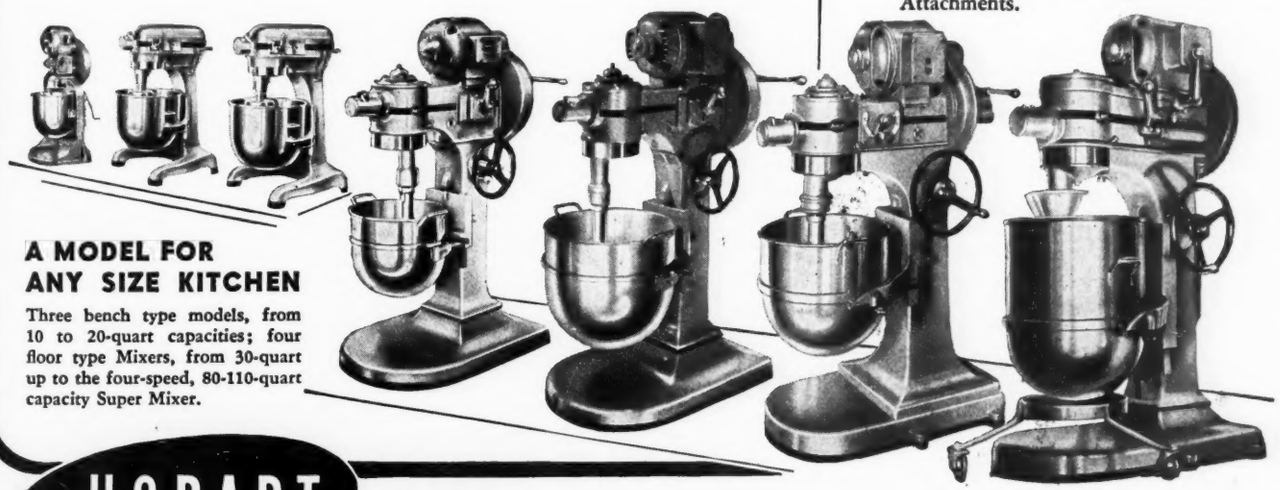

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Sixty Administrators Go to Minnesota Institute

Sixty administrators and assistant administrators attended the fourth institute for hospital administrators held at the Center for Continuation Study of the University of Minnesota, January 15 to 20. The faculty of the institute numbered 21, not including a large number of department heads of Minneapolis and St. Paul hospitals who took active part in the demonstrations. The institute was under the general direction of Dr. William A. O'Brien, Julius M. Nolte and Ray M. Amberg of the University of Minnesota; Gerhard Hartman, executive secretary of the American College of Hospital Administrators, and the officers and institute committee of the Minnesota Hospital Association.

Although most of the registrants were from Minnesota, some came from Iowa, Wisconsin and Illinois. Among the out-of-state members of the faculty were Bertha E. Beecher, Christ Hospital, Cincinnati; Graham L. Davis, W. K. Kellogg Foundation, Battle Creek, Mich.; James A. Hamilton, New Haven Hospital, New Haven, Conn.; Carl I. Flath, Michigan Society for Group Hospitalization, Detroit, and Alden B. Mills, The MODERN HOSPITAL.

Gifts Are Announced

Gifts and bequests announced during the month include $75,353 in cash to the Sisters of Charity of the Incarnate Word to erect an annex to St. Mary's Infirmary, McAlester, Okla.; $50,000 to build a hospital, to be known as Lemke Memorial Hospital in Wakeeney, Kan.; $15,000 to the Georgia Baptist Hospital, Atlanta, Ga., and $10,000 to St. Luke's Hospital, New York City, for cancer research during 1940. Donors are James B. Cambron of McAlester, the late John Lemke of Wakeeney and the Joseph B. Whitehead Foundation, respectively. The St. Luke's gift was anonymous.

Sydenham Staff in Dispute

A complicated dispute within the medical board of Sydenham Hospital, New York, has resulted in the resignation of about 40 members of the medical staff, a brawl in which one doctor received two broken ribs and the appointment of Dr. Julius Garcho, gynecologist as chairman, and Dr. Milton Friedman, radiotherapist, as secretary of the medical staff. Gustavus A. Rogers, president of the hospital, referred to the affair as mutiny. Some of the resignations are expected to be withdrawn in the near future.

Texas Hospital Association to Discuss Nursing Problems

The annual meeting of the Texas Hospital Association will be held at the Gunter Hotel, Houston, February 22 to 24. The morning session on Thursday will have group hospitalization as its theme, with Dr. Lucius R. Wilson, John Sealy Hospital, Galveston, and Bryce L. Twitty, administrator of Group Hospital Service, Inc., Dallas, as principal speakers. The afternoon meeting will cover hospital administration and accounting.

Both the morning and afternoon meetings on Friday will be devoted to various aspects of nursing, including such subjects as "Accreditation of Schools of Nursing," by Clara Quereau, R.N., of the National League of Nursing Education, New York, and "How the School of Nursing Can Be Made to Pay for Itself," by John G. Benson, D.D., superintendent of the Methodist Hospital, Indianapolis.

The meeting will close Saturday noon. Allied state associations that will meet with the hospital group include the Association of Record Librarians of North America, the Association of Nurse Anesthetists, the Association of Occupational Therapists and the American Physiotherapy Association.

Small Hospital Problems Stressed at Meeting of A. C. S. in New Orleans

Problems of small hospitals were emphasized at the hospital conference of the sectional meeting of the American College of Surgeons, held in New Orleans, January 17 to 19. The three day session opened on Wednesday morning with a symposium on small hospitals, at which Dr. Leon S. Lippincott, superintendent of the Vicksburg Sanitarium, Vicksburg, Miss., presided. Among the subjects discussed were "Securing and Maintaining Adequate and Competent Personnel in the Small Hospital," by Helen Branham, R.N., superintendent, North Mississippi Community Hospital, Tupelo, Miss.; "Securing Good Medical Records in the Small Hospital," by Dr. V. B. Philpot, superintendent, Houston Hospital, Houston, Miss., and "Providing Efficient Nursing Service for the Small Hospital," by Regina H. Kaplan, R.N., administrator, Leo N. Levi Memorial Hospital, Hot Springs, Ark.

The Wednesday afternoon program stressed the medical and clinical aspects of hospital work.

On Thursday morning, Dr. Lucius R. Wilson, superintendent of the John Sealy Hospital, Galveston, Tex., presided over a panel discussion on "Important Factors in the Rendering of Efficient Hospital Care of the Sick and Injured." Speakers included Dr. Frank R. Bradley, superintendent, Barnes Hospital, St. Louis, who talked on "Preparedness for Emergencies," and Dr. A. J. Hockett, superintendent, Touro Infirmary, New Orleans, who discussed "Preparation, Control and Technic in Handling Parenteral Solutions."

The Thursday afternoon meeting was devoted to a consultation round table conference on various aspects of hospital administration and standardization at which administrators presented their problems for discussion. The round table was conducted by Dr. A. J. Hockett with Dr. Lucius R. Wilson and Dr. Malcolm T. MacEachern collaborating.

A conference on the care of the obstetrical patient was held on Friday morning with Robert Jolly, superintendent, Memorial Hospital, Houston, Tex., presiding. Prenatal care, the patient in labor, postpartum care and care of the newborn were included in the discussion.

The session ended on Friday night with an open meeting on health conservation that was open to the public.

All of the meetings were marked by record attendance. The states represented at the conference were: Alabama, Arkansas, Florida, Georgia, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas.

Hospital Given $100,000 Fund

A trust fund of $100,000 has been established for Memorial Hospital, Houston, Tex., by Col. and Mrs. J. W. Neal as a memorial to their son, James Robert Neal, who died recently. The interest from the fund is to be paid to the hospital to provide x-ray treatment for patients who are unable to pay for it. In 1928 Colonel and Mrs. Neal set up a similar fund for the care of sick and disabled children in memory of their daughter.

Strong Memorial to Add Wing

Strong Memorial Hospital, Rochester, N. Y., is planning to build a six story wing, it was announced recently. The new building, which will cost approximately $500,000, will accommodate a maximum of 80 semi-private patients and 40 private patients. Ground will be broken for the new addition just as soon as plans can be prepared.

How to make the operating budget go farther! That problem continually confronts hospital superintendents and buyers.

How to keep surgeons and staff satisfied and happy! There is another problem, and one that cannot be side-stepped.

No matter what you are looking for in surgeons gloves—ability to stand up under maximum sterilizations or greatest possible comfort for the wearer—you will find it in Miller Surgeons Gloves.

Here are gloves made by a single dip into pure latex rubber. Tissue thin, they provide almost "bare hand" sensitivity.

Full across the back, they permit free flexing. Finger tip and hand tension is reduced to a minimum. Both cutinized and smooth surfaces. Preferences of surgeons and staff are met. And, because more sterilizations are possible, operating costs are reduced. The budget *does* go farther!

To all eyes, the familiar Miller trademark is an emblem of quality, satisfaction and economy. No wonder, then, that Miller has become *a one word* specification. Miller Rubber Co., Inc., Akron, O.

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ANODE SURGEONS GLOVES
ANODE FOUNTAIN SYRINGE
ANODE LATEX SURGICAL TUBING
ANODE HEATIATOR WATER BOTTLE
ANODE PENROSE DRAINAGE TUBING
ANODE HOSPITAL THROAT COLLAR

Lord Nuffield Sets Up Fund for British Hospital Work

Leaders of hospital thought in Britain came one step closer to their goal of achieving a more effective coordination of all voluntary and governmental hospital work when Lord Nuffield established a trust fund of 1,000,000 shares of Morris Motors stock as the nucleus of a central hospital fund for the hospitals outside of London.

In the January issue of *The Hospital,* Alderman W. Hyde, who has been designated secretary of the fund, outlined some observations regarding the purpose of the gift, which at present market rates is worth about £1,250,000 or between $5,000,000 and $6,000,000.

Hospitals are to be regionalized in accordance with the proposals of the Sankey commission in order to create a coordinated and fully effective national hospital service. Divisional hospital councils are to be organized. They will survey and coordinate local hospital facilities, develop and extend them where necessary and nominate regional representatives to serve on a central hospital board or council. The central board will coordinate voluntary and governmental hospital services throughout the country, allocate available money to regional councils and work with governmental departments for the development of hospital services.

Alderman Hyde states that the regionalization scheme should result in real economies in expenditure on both municipal and voluntary hospital services through cooperative action.

A.S.T.A. Warns Against Swindler

The American Surgical Trade Association has recently issued a warning to Detroit hospitals that a swindler, claiming to be an employe of a surgical dealer, has been calling on hospitals and doctors and obtaining surgical instruments on the pretense of repairing and replating them. The association also reported that a man who represents himself as an employe of a manufacturer of compressors and pumps has offered to repair this type of equipment at a low price. Hospitals that employed him discovered, after paying for the work, that no repairs whatever had been made.

New Hospital Bulletin

The first issue of *St. Luke's News,* a 16 page magazine published by St. Luke's hospital, Chicago, appeared January 22. The magazine, which is to be issued monthly, will contain articles by various members of the staff and news of the hospital personnel.

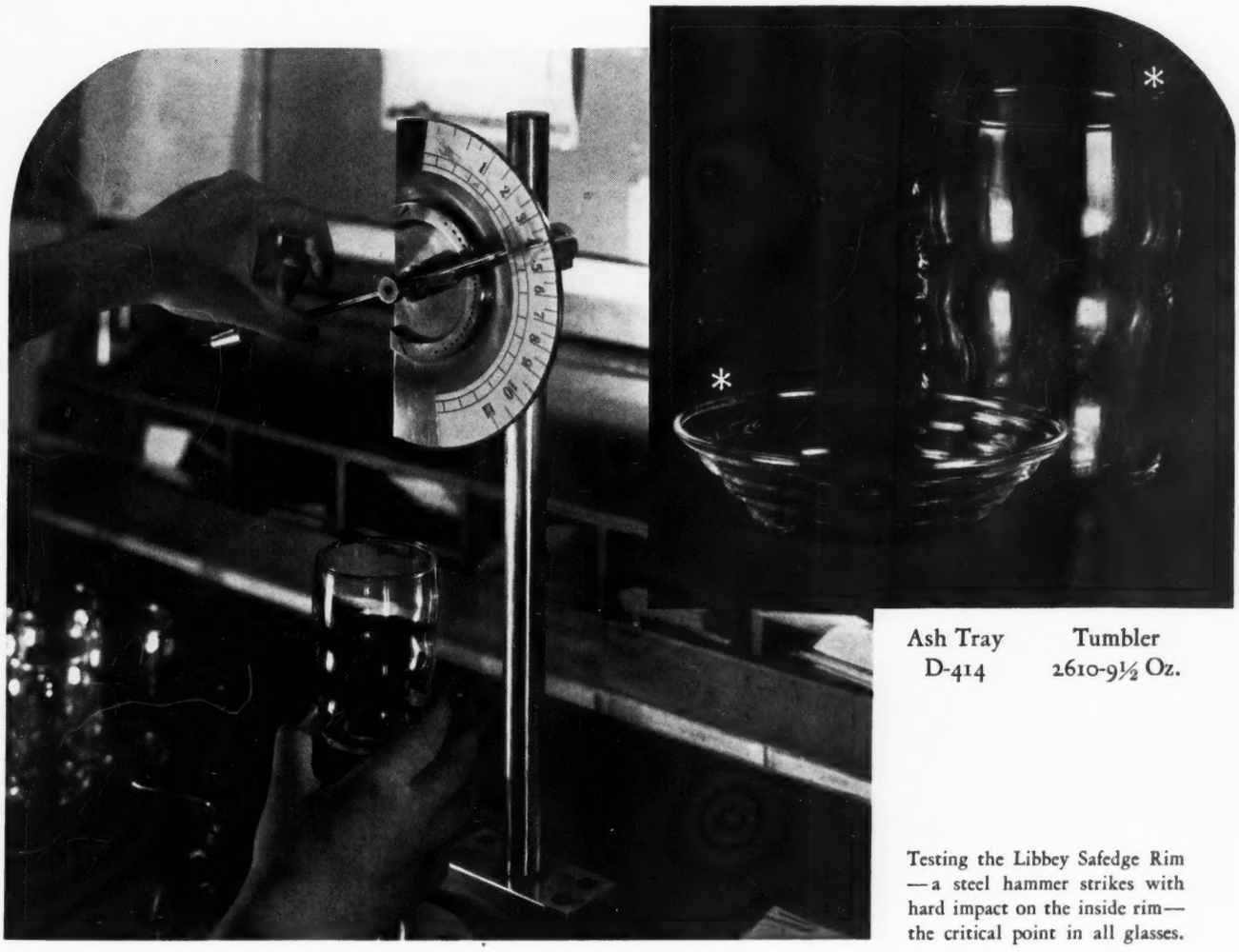
Nonprofit Plans Meet in Pittsburgh

Representatives of nonprofit group hospitalization plans from all over the United States met in Pittsburgh from January 24 to 26 at a Conference of Approved Hospital Service Plans. The delegates discussed such problems as reciprocal agreements between the various plans, types of service available to those protected and methods of enrollment. Among the speakers at the conference were Dr. Fred G. Carter, president of the American Hospital Association; Dr. Basil C. MacLean, chairman of the committee on hospital service of the A.H.A.; C. Rufus Rorem, director of the committee on hospital service, and Dr. S. S. Goldwater, commissioner of the New York City department of hospitals, who is a member of the committee.

New Hospital for Pittsfield, Ill.

The Commonwealth Fund, as a part of its rural hospital program, will build a hospital of not more than 40 beds in Pittsfield, Ill., a town of 3500 surrounded by a possible hospital clientele of 40,000 people. The lack of an experienced surgeon must be met by community initiative before a hospital can function in accordance with the fund's standards, according to the annual report of the fund.

Case Histories prove Libbey Safedge Glassware is a money-saver for hospitals



Ash Tray D-414 — Tumbler 2610-9½ Oz.

Testing the Libbey Safedge Rim—a steel hammer strikes with hard impact on the inside rim—the critical point in all glasses.

In the Libbey Glass plant "case histories" are kept on every "run" of glassware. These are records compiled from tests made hourly on samples picked at random out of the "run." The tests are comparable to hazards the glassware must withstand in actual service. They prove that it is resistant to *thermal shock* and the blows of hard usage. The exclusive Safedge rim—6 times stronger than side walls—is guaranteed against chipping. Libbey Glassware is a dependable money-saver in hospital equipment.

In addition to these practical advantages, Libbey Glassware is appealing to look at, pleasing to hold and creates a "homelike" touch to which patients are quick to respond. The unique Ash-Tray, illustrated above, has many special features of interest to hospitals. Cigarettes cannot fall out . . . it is easily cleaned and the edges won't chip—it has the Safedge, too. Ask your Libbey dealer to show you samples of our complete line. Libbey Glass Company, Toledo. Branches in principal cities.

Libbey's SAFEDGE GUARANTEE
A NEW GLASS IF THE RIM CHIPS

LIBBEY SAFEDGE GLASSES

Names in the News

Administrators

DR. J. L. EVANS, president of the medical staff at North Hudson Hospital, Weehawken, N. J., has been appointed administrator of the institution to succeed MARY A. SMITH.

RONALD D. YAW has been named acting director of Blodgett Memorial Hospital, Grand Rapids, Mich., following the resignation of DR. JOHN E. GORRELL. Mr. Yaw has been connected with the hospital as Doctor Gorrell's assistant since 1938.

MRS. HELEN T. STABLER, formerly superintendent of the J. C. Blair Memorial Hospital, Huntingdon, Pa., has assumed a similar position at Montgomery Hospital, Norristown, Pa. MARGARET WILLIAMSON, the former superintendent, resigned recently.

DR. M. L. DRYFUS has resigned from Mount Sinai Hospital, New York City, to become executive director of the Home for Aged and Infirm Hebrews, New York.

DR. J. V. PACE, superintendent of Indiana State Sanatorium, Rockville, Ind., has been appointed head of the new Silvercrest Tuberculosis Hospital at New Albany, Ind., according to an announcement by DR. AUGUST P. HAUSS, acting superintendent of the institution.

MARY A. RYAN, formerly assistant superintendent of Rockaway Beach Hospital, Rockaway Beach, N. Y., has been appointed acting superintendent by the board of directors. Miss Ryan has been associated with the institution for eight years.

HENRY R. BAKER, retiring superintendent of Brooklyn Eye and Ear Hospital, Brooklyn, N. Y., was honored at a dinner held on December 13 by the medical staff of the hospital. Mr. Baker has served as head of the hospital for thirty-two years. When he became associated with it in 1907, the institution had a capacity of 70 beds; it now accommodates 200 patients. The building in which the hospital is now housed was built in 1930 at a cost of $1,000,000. HENRY J. WILLIAMS succeeds Mr. Baker as superintendent.

WALTER H. MENDE was appointed superintendent of Broad Street Hospital, New York City, by the board of directors after a reorganization of the hospital staff. At the meeting of the board HENRY LOCKHART JR. was elected chairman; WILLIAM H. COVERDALE, president; PERCY C. MAGNUS, vice president, and JOHN D. REILLY, treasurer. Mr. Mende was also elected secretary of the board of directors.

DR. WILLIAM HINDLE has been appointed superintendent of Charles V. Chapin Hospital, Providence, R. I.

LANG B. DAVIS has been appointed superintendent of Cimarron Valley Wesley Hospital, Guthrie, Okla., it was recently announced by the board of directors of the institution. Mr. Davis replaces MRS. MARION W. BROOKS, who has been head of the hospital for the last two years.

LESTER HALE has been named superintendent of Rouse Hospital at Youngsville, Pa., by the county commissioners. He succeeds MRS. WALTER WARD. Mrs. Hale was given the position of matron of the institution.

HARRY W. BENJAMIN, formerly associate superintendent of Mount Sinai Hospital, Philadelphia, has been appointed superintendent to succeed FRANCES L. LOFTUS, R.N., who resigned recently.

DR. T. R. FRAZER, in charge of the division for the criminal insane at Ful-

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Golden Anniversary

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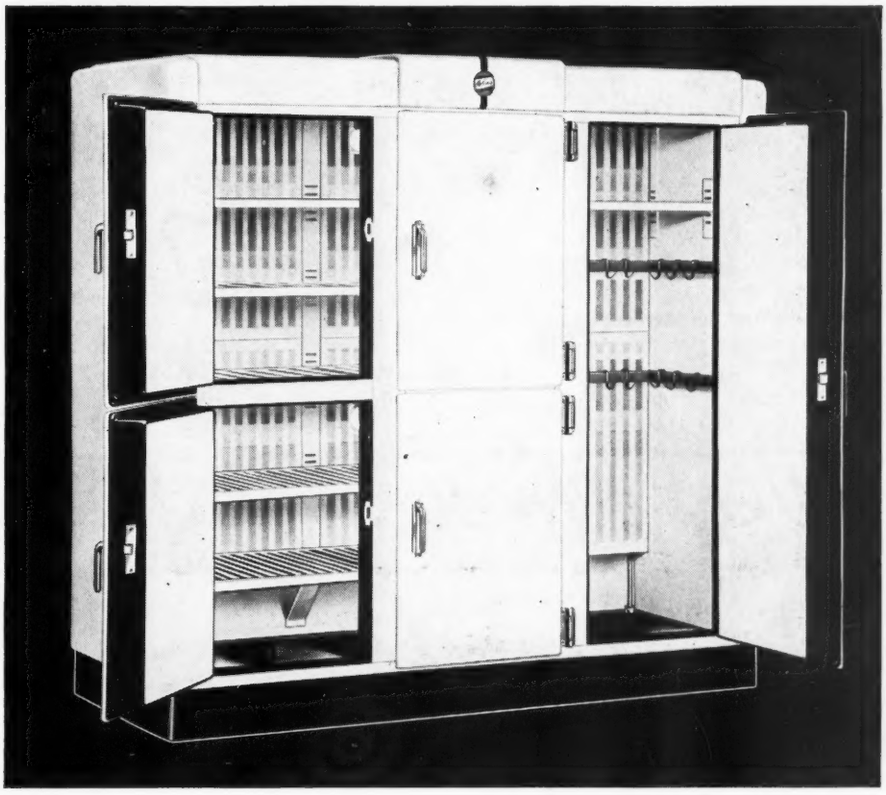

● Experience does count! The fifty years of "knowing how," back of the Golden Anniversary Models by McCray are important to all users of commercial refrigeration.

Embodied in this complete new line are advanced engineering features and in-built quality which assure efficient refrigeration at low cost of operation.

Right now is the time to check your refrigerator equipment. Quit feeding dollars to greedy old refrigerators—replace with modern, cost-saving McCrays, reduce power bills and spoilage losses. For hospitals there are McCray models to meet all requirements, in the general kitchen, diet kitchens, laboratories, mortuary. Ask the McCray man or write the factory for complete information about models to meet your needs.

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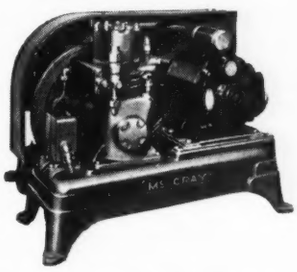

BALANCED Refrigeration by McCray, with cabinet, coils and compressor engineered for use together, means more efficiency, lower costs. McCray compressors are built in sizes to meet all requirements and factory engineers specify the correct model to cool each McCray cabinet.

FIFTY YEARS OF PROGRESS IN COMMERCIAL REFRIGERATION

ton State Hospital, Fulton, Mo., is retiring to resume private practice. Doctor Frazer was formerly superintendent of the institution.

Dr. Thomas I. Cotton has resigned as superintendent of Selinsgrove State Colony for Epileptics, Selinsgrove, Pa. He will be succeeded by Dr. Roland Mackintosh, who was formerly assistant superintendent of Norristown State Hospital, Norristown, Pa.

John J. Rogerson, who has been manager of Hartford Hospital, Hartford, Conn., since 1936 and associated with it since 1908, has submitted his resignation to take effect April 1. A dinner was held in Mr. Rogerson's honor at which his services to the institution were praised by executives of the hospital, including Col. Louis R. Cheney, president of the board, and Dr. Wilmar M. Allen, director of the hospital. W. Enos Cornett, assistant manager, will take over Mr. Rogerson's duties.

Hazel McIver, R.N., of Claremont, N. H., has been named head of New London Hospital, New London, N. H. Miss McIver succeeds Marion Wallace, who resigned recently.

Wilda Hornberger, superintendent of Woman's Hospital, Cleveland, is retiring after seventeen years of service with the institution.

Hilda Hardt, R.N., has been appointed superintendent of Minnewaska Hospital, Starbuck, Minn., succeeding Myrtle C. Kvenvold.

Dr. W. W. Frank, medical director of Hinsdale Sanitarium and Hospital, Hinsdale, Ill., resigned on January 1 to enter private practice. G. C. Hoskin, treasurer of the hospital, is acting superintendent of the institution.

Department Heads

Helen C. MacLean has been made chief dietitian of Waterbury Hospital, Waterbury, Conn. Miss MacLean was formerly chief dietitian at Memorial Hospital, Worcester, Mass.

La Verne Balzer, R.N., director of nursing at Queen of Angels Hospital, Los Angeles, has accepted the position of director of nursing at Ravenswood Hospital, Chicago. Miss Balzer replaces Alice P. Maull, R.N., who resigned because of ill health.

Dr. Nevin H. Rupp has been appointed to the recently created position of chief of the anesthesia service at Reading Hospital, Reading, Pa. Doctor Rupp was formerly chief of the anesthesia department at Stephan Memorial Hospital, Ephrata, Pa.

Dr. Arthur B. Van Loon, who has been associated with Memorial Hospital, Albany, N. Y., for the last forty-five years, resigned as chief surgeon on December 31.

Trustees

Norton McKean was reelected president of the board of trustees of Memorial Hospital, Albany, N. Y., at the board's annual meeting in January. Others reelected were Julius Illch and William C. Dearstyne, vice presidents, and Edward S. Poole, secretary. J. Stanley Davis was elected treasurer.

William J. Griffin was reelected president of the Michigan Society for Group Hospitalization at the first annual meeting of the board of trustees. Other officers reelected included Dr. Stewart Hamilton, vice president; Dr. W. L. Babcock, treasurer, and John R. Mannix, secretary. Carl I. Flath, superintendent of Wellesley Hospital, Toronto, Ont., has been appointed assistant to Mr. Mannix.

Mason B. Coger was reelected president of the board of trustees of Corning Hospital, Corning, N. Y., at the annual meeting of the board. Mr. Coger has served in this capacity since 1931. Other officers reelected are John LeValley, vice president, and Walter W. Oakley, secretary-treasurer.

F. A. Nelson was reelected president of the board of directors of Graham Hospital, Canton, Ill., at the annual

ONCE *in a lifetime*

Invariably during one's lifetime comes the emergency of an operation. The patient comes to you in full faith and confidence believing that you are worthy of his trust . . . believing that you will leave no stone unturned to assure his safety during and after the operation. Whether it be major or minor, the successful recovery of the patient is, to a degree, dependent upon the scientific administration of anesthesia.

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is scientifically correct, safe, simple and economical . . . built to exceed the requirements of all anesthetists. The KINET-O-METER employs no concealed rubber bags, rubber diaphragms or other equally perishable parts for controlling gas pressures and flow. Its accurate, trouble-free, DRY FLOAT Flow Meters assure positive and easily controlled administration. No freezing, no filling, no sediment, no cleaning. Just years and years of safe, satisfactory, efficient, economical service. Available in Cart, Cabinet and Stand models.

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meeting of the board. Other officers re-elected are E. G. CARVER, vice president; L. C. WADDILL, secretary, and J. A. BUCHEN, treasurer.

WALTER GREY DUNNINGTON was recently elected a member of the board of governors of the Society of the New York Hospital, New York City.

ROBERT T. SHERMAN was reelected president of the board of trustees of Evanston Hospital, Evanston, Ill., at the annual meeting of the board. Other officers reelected include CHESTER A. COOK, first vice president; MRS. PERKINS B. BASS, secretary, and WILLIAM H. DUNHAM, treasurer.

Deaths

DR. FREDERICK E. BURLESON, president of Burleson Hospital, Grand Rapids, Mich., died recently. Doctor Burleson became associated with the institution in 1916. The hospital was founded by his brother, the late DR. WILLARD M. BURLESON.

Charlotte Hospital Seeks Funds

Charlotte Memorial Hospital, Charlotte, N. C., is seeking $150,000 in a financial campaign now going on. The firm of Ward, Wells and Dreshman of New York is directing the fund-raising effort.

Says Tuberculosis Is Not Hospital Personnel Problem

The incidence of tuberculosis among hospital workers is no greater than among other occupational groups, in the opinion of Dr. Leopold Brahdy, who reports statistics on the disease in the *Journal of the American Medical Association* for January 13.

His contention is that the high incidence of tuberculosis reported among hospital workers is due to the use of exhaustive case finding methods, such as x-ray examinations, which not only reveal cases having symptoms of the disease but also show the presence of tuberculous lesions of the lungs which appear, regress and heal without giving rise to symptoms or physical signs.

Doctor Brahdy's conclusions are at variance with those of Dr. J. Arthur Myers, whose series of articles on tuberculosis among hospital employes is appearing in this magazine.

Tuberculosis Workers to Gather

The annual meeting of the New York Tuberculosis and Health Association will be held jointly with the Tuberculosis Sanatorium Conference of Metropolitan New York on Tuesday, March 5, at the Hotel Pennsylvania in New York City.

Training Course for Librarians

For the fourth year the Division of Library Instruction of the University of Minnesota will give a course for the training of hospital librarians. It will be conducted during the spring quarter beginning April 1. The field for this specialized type of librarianship is steadily opening, as evidenced by inquiries received from hospital administrators, according to Frank K. Walter, university librarian. Miss Perrie Jones will again be in charge of the course.

Ground Broken for Hospital

Ground was broken in late December for construction of a 12 story building for Lebanon Hospital, the Bronx, New York. The structure will be the first of three hospital units to be built at a cost of $4,000,000. The groundbreaking ceremonies were cut short by cold weather.

Committee to Pick Medical Staff

A committee has been appointed by Dr. S. S. Goldwater to assist in selecting the staff of the Triboro Hospital, the new 500 bed institution for tuberculosis now approaching completion. The new hospital adjoins Queens General Hospital. The pathologist and roentgenologist will be selected from civil service lists.

TRADE NEWS

Nonskid Matting

• A nonskid safety matting designed to give long wear is being marketed by the AMERICAN MAT CORPORATION, 1717 Adams Street, Toledo, Ohio, for use around dishwashers and in laundries. The matting is available in either the Gro-Cord or the all black rubber type.

Metal Furniture Catalog

• The 1940 edition of the Royalchrome catalog, published by the ROYAL METAL MANUFACTURING COMPANY, 175 North Michigan Avenue, Chicago, features eight color pages of photographs of Royalchrome furniture. A new type of sectional furniture has been added to the line and is illustrated in the catalog.

Unbreakable Call Button

• A special exchange offer for new unbreakable equipment for nurses' call equipment has been announced by the HOLTZER-CABOT COMPANY, Boston. The new plug and receptacle that are included in the offer are rugged and foolproof and the whole assembly may be sterilized without affecting its serviceability.

Toilet Partitions

• The SANYMETAL PRODUCTS COMPANY, 1705 Urbana Road, Cleveland, has recently published a catalog that provides comprehensive and detailed information on partitions for toilet rooms, washrooms and locker rooms. A copy will be sent immediately upon request.

X-Ray Film File

• An improved steel file designed for filing x-ray plates is being manufactured by the GLOBE-WERNICKE COMPANY, Cincinnati. Each of the three drawers of the case is equipped with the Tri-Guard three rod filing principle so that the contents of the file are kept in an upright position without compression.

Dishwashing Compound

• Two dishwashing difficulties—the formation of hard water spots and film on dishes and glassware, and the accumulation of lime scale in dishwashing machines—are overcome by the use of Oakite Composition No. 63, according to a leaflet issued by the OAKITE PRODUCTS COMPANY, 14 Thames Street, New York.

Dehydrated Chicken Soup

• The CONTINENTAL COFFEE COMPANY, Chicago, has recently developed a dehydrated chicken soup mix. The mix is packed in 4½ ounce jars and when it is added to boiling water, makes a gallon of soup. The preparation of a clear soup requires only sixty seconds until it is ready to serve.

Fire Protection Chart

• A leaflet entitled "A Short Course in First-Aid Fire Protection," issued by the PYRENE MANUFACTURING COMPANY, Newark, N. J., specifies the various types of fires and the extinguishers that should be used in each case.

Personal Notes

• Dr. Lloyd L. Ely has joined the organization of DON BAXTER, INC., Glendale, Calif., in the capacity of medical director. . . . Frank T. Kalas, general sales manager of the ELECTRIC STORAGE BATTERY COMPANY, Philadelphia, was elected third vice president of the company at a recent meeting.

BOOKS ON REVIEW • • •

MATERNAL CARE AND SOME COMPLICATIONS. *By F. L. Adair, M.D., editor. Chicago: University of Chicago Press,* 1939. *Pp.* 194. $1.50.

The subject is well presented and should appeal to every individual interested in improving maternal care in this country. It enables the general practitioner to follow an outline of treatment used by the leading obstetricians. Normal obstetrics is stressed, and the signs and symptoms of complications are presented in such a manner that they can hardly be overlooked even by the physician who does obstetrics infrequently. The contraindications to various operative treatments in the home are important since special facilities and training are necessary to perform them. If these are followed, there is no doubt that better obstetrics will be obtained.

The section dealing with the three main causes of maternal mortality is complete and stimulating. It should make one hesitate to treat such complications except under the best conditions. It is only in this way that such deaths can be reduced.

The book fulfills its purpose of presenting the basic principles of maternal care and management of the major complications. It affords an opportunity for all those who care for maternity patients to acquaint themselves with facts that will improve obstetrics in the patient's home, as well as in the hospital.—JOHN B. PASTORE, M.D.

SOCIAL HYGIENE NURSING TECHNIQUES. *By Nadine B. Geitz, M.A., R.N. New York: American Social Hygiene Association.* 1939.

This pamphlet is much broader in scope than the name implies. It is a complete manual of social hygiene beginning with a brief discussion of the six venereal diseases with emphasis on syphilis and gonorrhea. A detailed description is given of clinical nursing procedures required in the diagnosis, treatment and follow-up. It presents the legal aspects involved in the control of venereal disease and introduces the agencies that cooperate with the health department.

For those who are interested enough to go farther, there is a bibliography of books and pamphlets. It should be an indispensable handbook to all nurses in the public health field and, in this day of increasing social hygiene consciousness, a valuable reference for any nurse.—CARRIE BELL MCNEILL, R.N.

HOSPITAL LIBRARIES. *By E. Kathleen Jones. Chicago: American Library Association,* 1939. *Pp.* 208. $2.50.

Having as its antecedent the "Hospital Library" (1923), which grew out of "A Thousand Books for the Hospital Library" (1913) and "What Can I Find to Read Aloud?" (1916), we have here a book that has been developing for twenty-six years, almost the period of hospital libraries per se. It is not surprising, therefore, to find the result a helpful, practical, authoritative handbook.

Designed primarily as "a guide to hospital librarians new to the service," it should be read to advantage by all hospital administrators and anyone having to do with hospital libraries.

The last chapter, there being eight in the book and also an appendix containing five pertinent sections, is entitled "The Present and the Future." It is an analysis of things as they really are and from the weaknesses indicated the line of future development is plotted.—MILDRED JORDAN.

READER OPINION • • • •

From Senator Wagner

Sirs:

I read with the greatest interest your recent analysis of the Senate Committee report, as well as your editorial on the National Health Program in the October issue of The Modern Hospital. I have repeatedly stated my intention to cooperate in redrafting the provisions of the National Health Bill to clarify its intent concerning the utilization of voluntary hospitals. I am deeply interested in the welfare of these hospitals and in assuring their continued and vigorous activity as an essential part of the National Health Program.

Robert F. Wagner,
Senator.

United States Senate,
Washington, D. C.

"Splendid Presentation"

Sirs:

It was only recently that I had my first opportunity to read the article, "What I Expect From My Board," by Dr. E. M. Bluestone in the August issue of The Modern Hospital. It is a splendid presentation. The article made definite the factual material vital to the relation between administrator and board. More important, however, it carried to the reader in a clear and incisive way the spirit that must govern both in a unified attempt to reach the highest perfection in service to patients.

Abraham Oseroff,
Director.

Montefiore Hospital,
Pittsburgh.

"Bombs" in Sterilizer

Sirs:

The critic of my article, "Asepsis in the Hospital Pharmacy," which appeared in the November issue of The Modern Hospital is entirely correct in his statement that a 500 cc. or 1000 cc. bottle sterilized and full of solution with the cap screwed down tight creates a live bomb. However, in the paragraph just previous to the one he questions, flasks are recommended, and in the paragraph that follows, the statement was made that the bottles are filled only half full.

Some danger is involved in sterilizing bottles that are full of solution and sealed. In view of this fact, the article should have been changed to read: "These bottles are sterilized with the caps screwed only moderately tight, with sufficient opening to permit the escape of air. After sterilization and before cooling the caps are retightened."

Roger K. Lager,
Pharmacist.

University Hospitals,
Cleveland.

Trustee Forum Enjoyed

Sirs:

I have enjoyed reading the trustee articles in The Modern Hospital more than any articles written this year and my trustees have enjoyed them, too. I have had reprints sent to them each month of the articles in the Trustee Forum. Strange as it may seem, there are a great many hospitals existing today that do not invite the superintendent or director to attend their meetings and in many of them there is no staff representation by invitation.

Jessie J. Turnbull,
Superintendent.

Elizabeth Steel Magee Hospital,
Pittsburgh.

RELAXATIVES • • • • •

Administrator's Fan Mail

• A postcard bearing the following address was received by the administrator of a New York hospital:

Dispensery
Goldbladder in Stumich Sickness
Outpatient Department c/o
_____ Hospital

• Letter received at Grace Hospital, New Haven, Conn.:

"My mother was a patient at the Grace. She fell and Dr. ——— operated on her. Then I was taking her to the Clinic for treatments. My mother was told not to go to the clinic any more. They have found excuse they said that her teeth was the cause of her hand not healing. When my mother fell she had the same teeth. What has her teeth got to do with her hand?

All Day to Do It

• As everybody knows, a hospital administrator has practically nothing to do—that is, nothing except: to decide what is to be done; to tell somebody to do it; to listen to reasons why it should not be done or why it should be done by somebody else or why it should be done a different way; to follow up to see if the thing has been done; to inquire why it has not been done; to follow up a second time; to discover that it has been done, but done incorrectly; to conclude that as long as it has been done, it may as well be left as it is; to consider how much simpler it would have been if he had done it himself in the first place but to realize that such an idea would strike at the very foundation of the belief that a hospital administrator has nothing to do.—*Bulletin of the Hospital Association of Pennsylvania.*

Hospital Book Titles

• *Cosmetic Surgery:* "Vanity Fair," Thackeray. "Skin Deep," Phillips.

Amputation: "Farewell to Arms," Hemingway.

Hydrotherapist: "I Cover the Waterfront," Miller.

Delinquent Intern: "Twenty Thousand Years in Sing Sing," Lawes.

Pediatrics: "The Yearling," Rawlings.

Record Librarian: "Personal History," Sheehan.

Bilateral Cataracts: "The Light That Failed," Kipling.

Typical Doctor's Notes: "I write as I Please," Duranty.

To the Rescue

• An Eastern hospital recently received the following announcement, the sender offering his services in curing cases that the doctors had given up as hopeless:

ONLY RADIOPATH EVER

Advanced Methods to Establish a Perfect State of Health in Mind and Body.

Electrifying Oriental and Occidental Massage . . . Scientific correction of spine, feet, etc., Zone-Therapy, Hydrotherapy, etc. Radiating solar contracting and expanding gravitational movements. Reducing or developing of streamline figure.

OLD AGE DEFERRED WEAKNESS BANISHED

Highest American and European References